Central Oregon Health Council

COHC Virtual Board Meeting
May 14, 2020
https://zoom.us/j/542240567
Dial In – See calendar invite for Zoom details to join from a computer
Phones: 1(669) 900-6833, Code: 542240567#

Welcome – Rick Treleaven

12:30 – 12:35 Introductions

12:35 – 12:40 Public Comment

12:40 – 12:45 Action Items & Approve Consent Agenda.....*vote*

12:45 – 12:50 Patient Story – Dan Stevens.....*information*

12:50 – 1:20 Public Health Update - Dr. George Conway, Muriel DeLaVergne-Brown, Mike Baker.....*information*

Long-Term Systemic Change

1:20 – 1:35 East Cascades Works – Jessica Fitzpatrick.....*information*
Attachment: Flyer

1:35 – 2:35 Governance ENDs/Purpose– Linda Johnson.....*discussion*

2:35 – 3:00 Strategic Plan Review – Donna Mills.....*discussion*
Attachment: Strategic Plan Draft

RHA/RHIP

Governance

3:00 – 3:15 CCO Q1 2020 Metric Report – Lindsey Hopper.....*information*
Attachment: Report

Consent Agenda

- February 2020 Board Minutes
- January, February, & March 2020 COHC Financials
- CCO Dashboard February, March, & April
- Ratify e-votes – 2019 Early QIM Funds Release & 2020 QIM Withhold
- CCO TQS 2020
- Dr. Gary Allen as interim representative for Advantage Dental

Written Reports

- Executive Director Update
- February 2020 CAC Minutes
- COVID Mini-Grant Report

MINUTES OF A MEETING OF

THE BOARD OF DIRECTORS OF

CENTRAL OREGON HEALTH COUNCIL

HELD AT ADVANTAGE DENTAL

442 SW UMATILLA AVENUE, REDMOND

February 13, 2020

A meeting of the Board of Directors (the ***"Board"***) of Central Oregon Health Council, an Oregon public benefit corporation (the ***"Corporation"***), was held at 12:30 p.m. Pacific Standard Time on February 13, 2020, at Advantage Dental, in Redmond, Oregon. Notice of the meeting had been sent to all members of the Board in accordance with the Corporation's bylaws.

Directors Present: Rick Treleaven, Chair

Linda Johnson, Vice Chair

Patti Adair

Paul Andrews, Ed.D

Tammy Baney (dial-in)

Seth Crawford

Megan Haase, FNP

Linda McCoy

Ellie Naderi

Divya Sharma, MD

	Kelly Simmelink
	Dan Stevens
	Jenn Welander
Directors Absent:	Eric Alexander
	Justin Sivill
Guests Present:	MaCayla Arsenault, Central Oregon Health Council
	Rebeckah Berry, Central Oregon Health Council
	Suzanne Browning, Kemple Memorial Clinic
	Gwen Jones, Central Oregon Health Council
	Elaine Knobbs-Seasholtz, Mosaic Medical
	Jim Lussier, The Lussier Center
	Donna Mills, Central Oregon Health Council
	Leslie Neugebauer, PacificSource
	Kelsey Seymour, Central Oregon Health Council
	Renee Wirth, Central Oregon Health Council

Mr. Treleaven served as Chair of the meeting and Ms. Seymour served as Secretary of the meeting. Mr. Treleaven called the meeting to order and announced that a quorum of directors was present and the meeting, having been duly convened in accordance with the Corporation's bylaws, was ready to proceed with business.

WELCOME

Mr. Treleaven welcomed all attendees to the meeting; introductions were made around the room and on the phone.

PUBLIC COMMENT

Mr. Treleaven welcomed public comment. Ms. Browning announced that Kemple Memorial Clinic is closing because children with dental care needs are now covered and the organization's overall mission has been fulfilled. She and Ms. Knobbs-Seasholtz shared that the organization will fold into Mosaic Medical.

CONSENT AGENDA

The consent agenda included the January minutes, the auditor selection, and COHC Financials for December.

MOTION TO APPROVE: Mr. Alexander motioned to approve the consent agenda; Mr. Andrews seconded. The motion was approved.

PATIENT STORY

Mr. Andrews shared the story of an elementary student he called Jay. Mr. Andrews shared that Jay was exposed to drugs in utero, was placed into DHS custody, and his parents were incarcerated. Mr. Andrews noted that Jay was diagnosed with articulation issues, PTSD, ADHD and as Intellectually & Developmentally Disabled (IDD). Mr. Andrews shared that Jay lives with his grandparents in La Pine, and after he was removed from school due to behavioral issues he was invited into a joint program between Bend La Pine Schools and the High Desert Education Service District (HDESD) that assigned him a mentor. Mr. Andrews shared that Jay has now been adopted by his grandparents and has been reinstated at school, and that Jay will need long-term support in order to succeed.

GOVERNANCE COMMITTEE

Ms. Johnson shared the Governance Committee's intent to clarify the Ends statement for the COHC. She explained the Ends statement will articulate who the moral owners are of the COHC, the relationships and division of responsibilities between Board and staff, the board's role and how they measure their effectiveness.

Mr. Lussier shared his expertise and recommendations with the Board for pursuing their Ends statement. The Board discussed his suggestions with him.

2020 BUDGET

Ms. Neugebauer explained that the motion made and approved by the Board last month regarding the CCO Budget came as a surprise to PacificSource. She asked the Board to reconsider their motion that

PacificSource should amend their budget to reflect a 2% profit margin. She shared that PacificSource's budget methodology is consistent across all lines of business and is designed to to reflect actual expectations, not desired performance. She added that she is happy to bring the early assumptions that are used to develop the budget each year in the fall for the Board to review.

The Board elected to amend the motion they made at the January meeting.

MOTION TO APPROVE: Mr. Andrews motioned to approve the 2020 CCO budget as originally presented, contingent that the Cost and Utilization Steering Committee determines metrics to accomplished a 2% minimum margin. Ms. Johnson seconded; all were in favor, the motion passed unanimously.

The Board discussed the issue of timing regarding when they review the budget each year.

MOTION TO APPROVE: Ms. Welander motioned to direct the Finance Committee and the CCO to establish a budget process that allows for input and iteration in a timely manner to ensure all affected parties' objectives are met in all future CCO budgets. Ms. Johnson seconded; all were in favor, the motion passed unanimously.

CCO 2019 Q4 METRICS

Ms. Neugebauer reviewed the metrics. She shared that Ms. Lindsey Hopper of PacificSource will be present at the May meeting to deliver the Q1 2020 updates.

WORKFORCE DEVELOPMENT

Ms. Horton-Dunbar shared that CCO 2.0 has new requirements regarding workforce development. She noted that there is a need for Traditional Health Workers (THWs), which include doulas, Community Health Workers, Peer Support Specialists, Peer Wellness Specialists, and Peer Health Navigators. Opportunities for pursuing a workforce development pipeline were discussed amongst those in the room.

STRATEGIC PLANNING

Ms. Berry asked Board members to gather in groups and answer questions that will inform the strategic plan development at the retreat next month. She showed them the results of their work up to this point; they requested the information be displayed in a different format.

Ms. Berry explained the upcoming process for the March Retreat, noting that a draft will be shared in April and the final version will be available for review in May.

ACTION: Ms. Berry will reformat the Board's prep work for the strategic plan.

ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 3:25 pm Pacific Standard Time.

Respectfully submitted,

_____

Kelsey Seymour, Secretary

Central Oregon Health Council
Statement of Financial Position
YTD 1.31.2020

ASSETS	**General Fund**
Total Checking/Savings	$ 19,074,641
COPA - Security Deposit	1,997
TOTAL ASSETS	$ 19,076,638
LIABILITIES & EQUITY	
Accounts Payable	$ 9,608
Payroll Payable (PTO Accrual)	29,193
	38,801
Grants Payable	2,696,824
	2,735,625
	16,341,012
TOTAL LIABILITIES & EQUITY	$ 19,076,637

Revenue	Actual	Budget	% Variance	
Operating Revenue	$ 81,582	$ 70,833	15%	
Community Impact Funds	251,021	208,333	20%	
Grants	20,316	24,583	-17%	
Interest income	57,161	12,500	357%	
Total Revenue	410,080	316,250	30%	
Expenses				
Operating Expense	124,483	121,165	-3%	
Community Impact Funds*	37,864	208,333	82%	**
Total Expenses	162,347	329,499	51%	
Net Income	$ 247,733	$ (13,249)	-1970%	

* **Community Impact Funds - Top 4 funded 2020**	
COIC	$37,864
	-
	-
	-
All other	-
	$ 37,864

****Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.**

***** *** The Finance Committee is not in receipt of PSCS December 31, 2019 Financials as yet*******

Central Oregon Health Council
Statement of Financial Position
YTD 2.29.2020

ASSETS	**General Fund**
Total Checking/Savings	$ 19,097,283
COPA - Security Deposit	1,997
TOTAL ASSETS	$ 19,099,280
LIABILITIES & EQUITY	
Accounts Payable	$ 19,051
Payroll Payable (PTO Accrual)	29,193
	48,244
Grants Payable	2,677,711
	2,725,955
	16,373,325
TOTAL LIABILITIES & EQUITY	$ 19,099,280

Revenue	Actual	Budget	% Variance	
Operating Revenue	$ 163,175	$ 141,667	15%	
Community Impact Funds	502,076	416,667	20%	
Grants	40,632	49,167	-17%	
Interest income	89,778	25,000	259%	
Total Revenue	795,661	632,500	26%	
Expenses				
Operating Expense	215,581	242,331	11%	
Community Impact Funds*	300,034	416,667	28%	**
Total Expenses	515,615	658,997	22%	
Net Income	$ 280,046	$ (26,497)	-1157%	

* **Community Impact Funds - Top 4 funded 2020**	
Rimrock Trails	$ 141,915
THRIVE	124,303
COIC	37,864
	-
All other	(4,048)
	$ 300,034

****Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.**

***** *** The Finance Committee found no material budget variances on the PSCS December 2019 Financials********

Central Oregon Health Council
Statement of Financial Position
YTD 3.31.2020

ASSETS	**General Fund**
Total Checking/Savings	$ 19,103,612
COPA - Security Deposit	1,997
TOTAL ASSETS	$ 19,105,609
LIABILITIES & EQUITY	
Accounts Payable	$ 1,923
Payroll Payable (PTO Accrual)	29,193
	31,116
Grants Payable	2,393,995
	2,425,111
	16,680,498
TOTAL LIABILITIES & EQUITY	$ 19,105,609

Revenue	Actual	Budget	% Variance	
Operating Revenue	$ 249,689	$ 212,500	18%	
Community Impact Funds	768,273	625,000	23%	
Grants	60,948	73,750	-17%	
Interest income	103,622	37,500	176%	
Total Revenue	1,182,532	948,750	25%	
Expenses				
Operating Expense	306,279	363,496	16%	
Community Impact Funds*	300,034	625,000	52%	**
Total Expenses	606,313	988,496	39%	
Net Income	$ 576,219	$ (39,746)	-1550%	

* **Community Impact Funds - Top 4 funded 2020**	
Rimrock Trails	$ 141,915
THRIVE	124,303
COIC	37,864
	-
All other	(4,048)
	$ 300,034

****Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.**

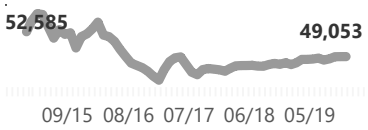
***** *** The Finance Committee found no material budget variances on the PSCS December 2019 Financials********

Central OR CCO

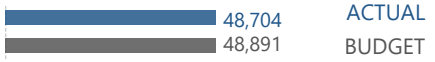
Coordinated Care Organization (Medicaid) 2/7/2020

PacificSource Community Solutions

MEMBER COUNTS Dec 2019 **49,053** Members **20,287** children **28,766** adults



AVG MEMBERSHIP (YEAR TO DATE FROM FINANCE)

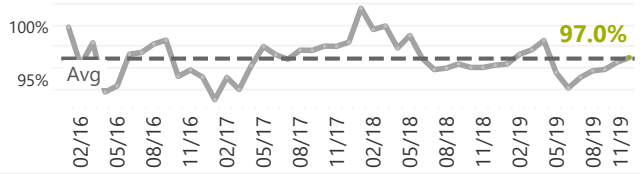


COST OF CARE

= Budget

		Actual PMPM	Difference from Budget
Medical Excl. Cap	12/18	$131.47	($13.76)
	11/19	$166.68	($27.41)
Dental	12/18	$25.85	($0.99)
	11/19	$26.76	($1.28)
Pharmacy	12/18	$64.15	$4.66
	11/19	$65.48	$3.63
Capitated BH, PCP, Hosp	12/18	$167.56	($0.48)
	11/19	$152.43	$11.29
TOTAL EXPENSES	12/18	$403.13	($12.94)
	11/19	$430.94	($14.61)

Expenses & Claims Over Revenue (YTD)

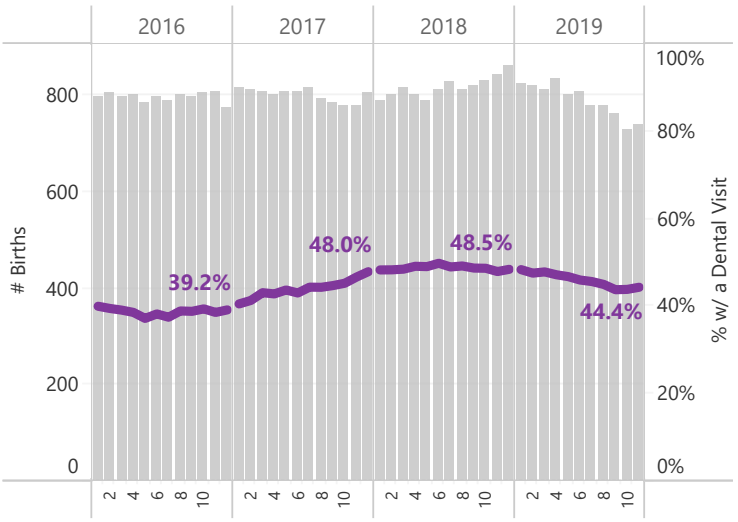


FOCUS ON: MATERNITY CARE

% of Members w/ A Dental Visit During Pregnancy*, Rolling 12-mos rate

1/2016 - 11/2019 *no completion factor applied*

BARS = # Live Births | LINE = % of Members w/ a Dental Visit



* % of females w/ *live birth* who had 90+ days of dental eligibility and at least one dental visit of any kind in the 280 days prior to delivery. (Age 15+ years old)

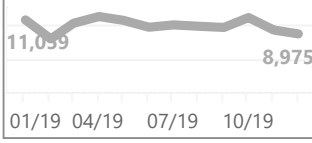
ACCESS & UTILIZATION

(1/2017 to 12/2019, paid thru 1/2020; no completion factor applied)

RATE Per Member Per Year	Behavioral Health (BH)	2017	2.8
		2018	3.3
		2019 YTD	3.6
	Dental	2017	1.1
		2018	1.1
		2019 YTD	1.0
	Primary Care (PCP)	2017	2.5
		2018	2.4
		2019 YTD	2.3
% OF MEMBERS (Unique Mems)	Behavioral Health (BH)	2017	18%
		2018	21%
		2019 YTD	22%
	Dental	2017	35%
		2018	37%
		2019 YTD	34%
	Primary Care (PCP)	2017	59%
		2018	61%
		2019 YTD	58%
	Any Claim	2017	79%
		2018	82%
		2019 YTD	79%

NEMT

#SERVICES (ALL TYPES)



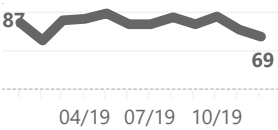
Members since 1/2019:

4,476 NEMT

517 SUD RES

SUD RES & DETOX

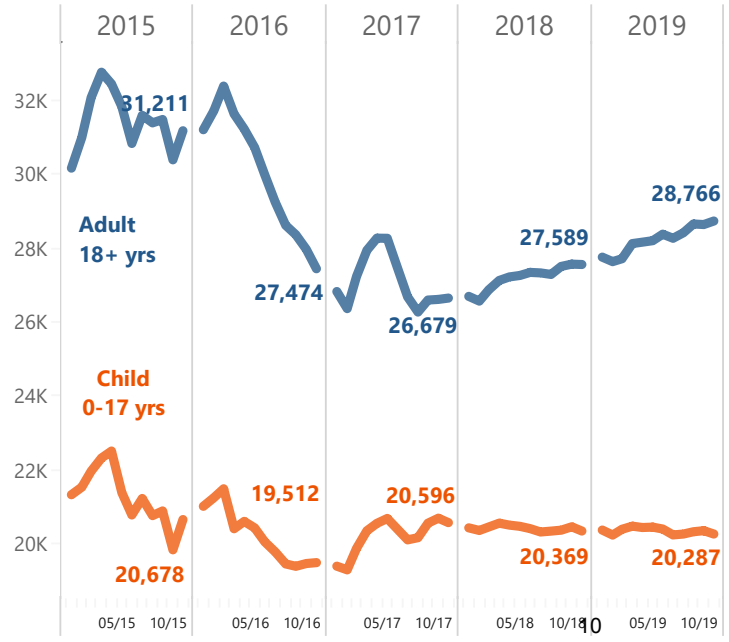
MEMBERS



AVERAGE MONTHLY MEMBERSHIP OVER TIME

ADULTS AND CHILDREN, 1/2015 -12/2019

Blue = Adults | Orange = Children

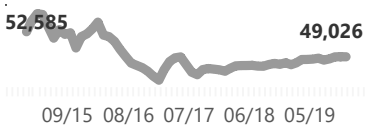


Central OR CCO

Coordinated Care Organization (Medicaid) 03/06/2020

PacificSource Community Solutions

MEMBER COUNTS Dec 2019 **49,026** Members **20,287** children **28,739** adults



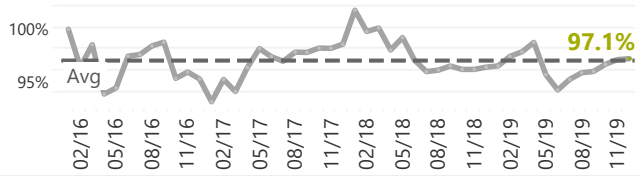
AVG MEMBERSHIP (YEAR TO DATE FROM FINANCE)

COST OF CARE

= Budget

		Actual PMPM	Difference from Budget
Medical Excl. Cap	12/18	$131.47	($13.76)
	12/19	$164.25	($24.54)
Dental	12/18	$25.85	($0.99)
	12/19	$26.77	($1.28)
Pharmacy	12/18	$64.15	$4.66
	12/19	$66.39	$2.95
Capitated BH, PCP, Hosp	12/18	$167.56	($0.48)
	12/19	$157.06	$6.65
TOTAL EXPENSES	12/18	$403.13	($12.94)
	12/19	$433.87	($16.90)

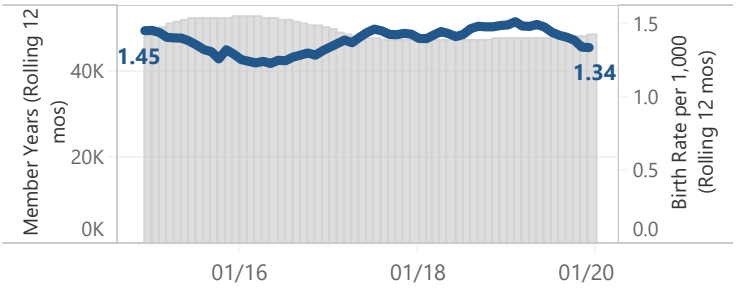
Expenses & Claims Over Revenue (YTD)



FOCUS ON: MATERNITY

BIRTH RATE (Rolling 12 mos)

Bars = Avg Membership (Rolling 12 mos)
Line = Live Birth Rate per 1,000 (Rolling 12 mos)



LIVE BIRTHS BY YEAR

Rolling 12-month Count

Uses Denominator for Prenatal and Postpartum Care QIM Measures
No completion factor applied

12/14	12/15	12/16	12/17	12/18	12/19
842	819	795	812	851	778

ACCESS & UTILIZATION

(1/2017 to 12/2019, paid thru 2/2020; no completion factor applied)

RATE Per Member Per Year	Behavioral Health (BH)	2017	2.8
		2018	3.3
		2019 YTD	3.6
	Dental	2017	1.1
		2018	1.1
		2019 YTD	1.0
	Primary Care (PCP)	2017	2.5
		2018	2.4
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% OF MEMBERS (Unique Mems)	Behavioral Health (BH)	2017	18%
		2018	21%
		2019 YTD	22%
	Dental	2017	35%
		2018	37%
		2019 YTD	34%
	Primary Care (PCP)	2017	59%
		2018	61%
		2019 YTD	58%
	Any Claim	2017	79%
		2018	82%
		2019 YTD	79%

NEMT
#SERVICES (ALL TYPES)

Members since 1/2019:

4,515 NEMT

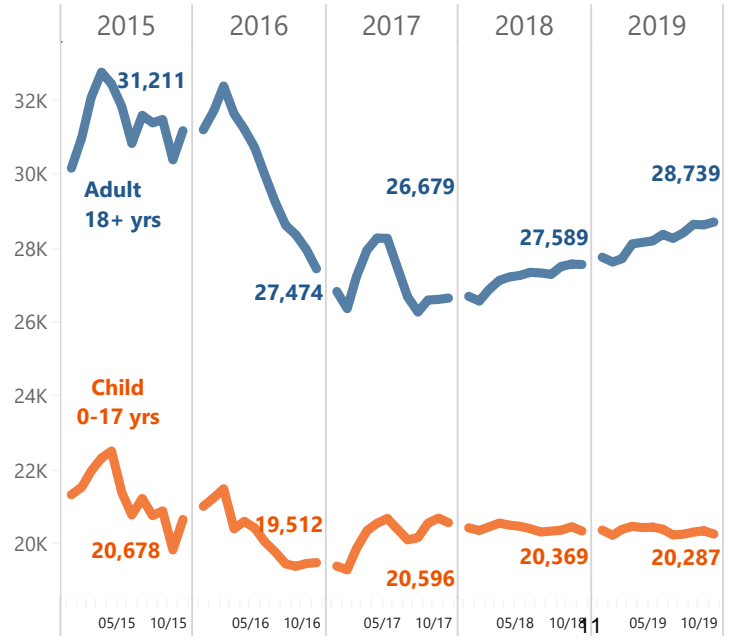
522 SUD RES

SUD RES & DETOX
MEMBERS

AVERAGE MONTHLY MEMBERSHIP OVER TIME

ADULTS AND CHILDREN, 1/2015 -12/2019

Blue = Adults | Orange = Children



Central OR CCO

Coordinated Care Organization (Medicaid) 04/03/2020

PacificSource Community Solutions

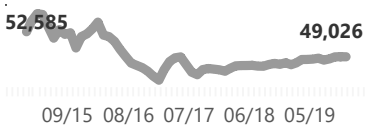
MEMBER COUNTS

Dec 2019

49,026 Members

20,288 children

28,738 adults



AVG MEMBERSHIP (YEAR TO DATE FROM FINANCE)

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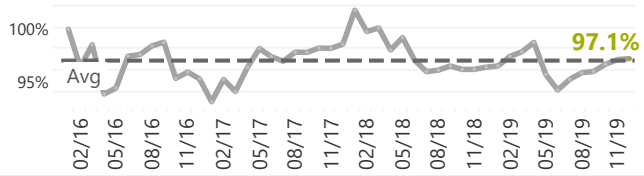
Expenses & Claims Over Revenue (YTD)



FOCUS ON: ED & PCP UTILIZATION

Emergency Dept & Primary Care Utilization by Member Zipcode

		% w/ PCP Visit	Avg	% w/ ED Visit	Avg	# ED Visits per 100 PCP Visits*	Avg
Bend	2017	59%	59%	17%	17%	17	18
	2018	61%		18%		19	
	2019	58%		17%		19	
La Pine	2017	60%	59%	20%	19%	18	19
	2018	60%		19%		19	
	2019	56%		17%		18	
Sisters	2017	59%	60%	16%	15%	16	15
	2018	62%		15%		16	
	2019	60%		14%		13	
Culver, Madras, Warm Springs	2017	58%	60%	35%	34%	39	40
	2018	61%		35%		40	
	2019	61%		34%		40	
Prineville, Powell Butte	2017	61%	61%	34%	34%	35	37
	2018	63%		35%		38	
	2019	60%		32%		37	
Redmond, Terrebonne	2017	61%	62%	26%	25%	24	25
	2018	64%		26%		25	
	2019	60%		24%		26	
All Others	2017	50%	53%	19%	21%	21	24
	2018	55%		22%		23	
	2019	53%		22%		28	

* Number of ED visits for every 100 primary care visits. Lower is often better.

ACCESS & UTILIZATION

(1/2016 to 12/2019, paid thru 02/2020; no completion factor applied)

RATE Per Member Per Year	Behavioral Health (BH)	2017	2.8
		2018	3.3
		2019 YTD	3.6
	Dental	2017	1.1
		2018	1.1
		2019 YTD	1.0
	Primary Care (PCP)	2017	2.5
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		2018	61%
		2019 YTD	58%
	Any Claim	2017	79%
		2018	82%
		2019 YTD	79%

NEMT

#SERVICES (ALL TYPES)

Members since 1/2019:

4,556 NEMT

526 SUD RES

SUD RES & DETOX

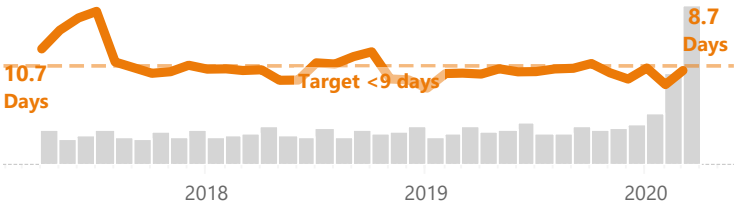
MEMBERS

OPERATIONS

(04/2017 to 03/2020)

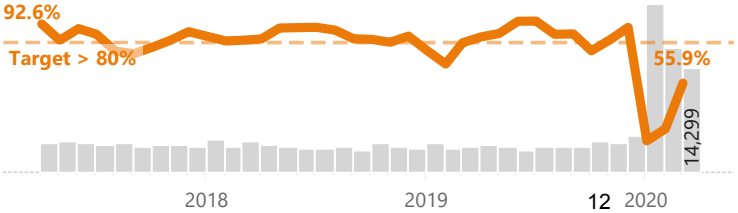
CLAIMS TURNAROUND TIME (DAYS)

Bars = # Claims **Line = Avg Turnaround Time (Days)**



CALL SERVICE LEVELS

Bars = Call Volume **Line = % Calls Answered w/in 30 seconds**



DEFINITIONS

Avg	Average
BH	Behavioral Health (mental health, substance abuse and addictions)
Cap	Capitation
Den	Dental Services
Detox	Detoxification Services. When expressed with Substance Use Disorder Residential (SUD RES) these are detoxification services provided in the residential setting.
General Administrative Expense (G&A)	Expenses related to the administration of the plan including, but not limited to, staff salary and benefits, telephone, depreciation, software licenses, utilities, compliance, etc.
Hosp	Hospital (when listed under "Capitated" label, only includes capitated inpatient services)
Medical Claims Expense	Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).
Mems	Members
MH/CD	Mental Health / Chemical Dependency
Misc	Miscellaneous Services not otherwise categorized.
MM	Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.
NEMT	Non-Emergent Medical Transport
Net Income	Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.
PCP	Primary Care Provider
PMPM	Per member per month
Premium Taxes & OMIP	State mandated taxes collected on a per member per month (PMPM) or % of premium basis.
QIM	Quality Incentive Measure program by Oregon Health Authority for Coordinated Care Organizations.
Rx	Prescription
SPMI	Severe and persistent mental illness. Members of all ages are included if diagnosed at any time with a condition outlined by OHA and USDOJ as SPMI. This includes certain depression diagnoses. Identification of members based on Medicaid CCO claims.
SUD	Substance Use Disorder
SUD RES	Substance Use Disorder Residential Treatment
Total Revenue	Premiums collected for insurance, net of HRA costs. Premiums for Oregon Health Plan recipients are received from the state of Oregon
Underwriting Income	Income after Operations and other activities not directly related to continuing operations.
Utilization	Use of a good or service
YTD	Year to date. For this dashboard, Financial YTD is based on the calendar year beginning January 1st.

***BCCP** & SPECIAL NEEDS RATE GROUP NOTE: As of 2017, Special Needs Rate Group (Rate Group X) is no longer a grouping by OHA. Starting in 2017, OHA used Rate Group X to classify Breast Cancer and Cervical Cancer Program members (BCCP).

NOTE: As of 4/2017, all financial PMPMs and cost bucketing comes from the Finance Department and no longer uses Actuarial bucketing. This means that costs, revenues and expenses are all presented on an ***paid date*** basis, regardless of what year they were incurred.

Board e-votes to be ratified:

4.6.2020

Good Afternoon COHC Board,

We have been presented with an early partial release of the 2019 QIM funds by the OHA. Their hope is that these funds would be placed into the community to support the needs across Central Oregon in response to the COVID-19 emergency. OHA is requiring a plan be provided back to them no later than end of day 4.10.2020. Although not the format we prefer, an e-vote is likely the most efficient at this point.

Typically the QIM dollars ($970k) would arrive around June 30th of the subsequent year (2020 for 2019) and according to our current process 60% would go back to the global budget and 40% would be held at PacificSource and COHC/PSCS would allocate grants.

***However, in order to meet the requirements as set forth by OHA now, the Finance Committee is recommending the following process to accomplish this requirement:

1. **Distribute QIM $$ using hybrid of 2019 JMA shared savings arrangement – exhibit 3. Provide targeted funding to public health and other providers impacted by COVID-19 ($970k).**
    a. 25% of available $$ allocated to Public Health departments using County attribution of OHP members

    Public Health 25% - $242k (other 25% divided by 4)
    CMHPs 6.2 + 6.25 = 12.45% - $121k

    SCHS 25.32 + 6.25 = 31.57% - $306k

    PCPs 11.74 + 6.25 = 17.99% - $174k

    DCOs 3.74 + 6.25 = 9.99% - $97k

Please let me know if you have any questions.***

Please return your e-vote to me by end of day Thursday 4.9.2020 (if not sooner

4.9.2020

Good Afternoon COHC BOD,

Please find a slide deck attached. This is 'Phase II' of OHA's efforts to infuse $$ into the provider community. Although, I would have preferred we presented this with 'Phase 1', PSCS was not quite ready.

***The Finance Committee is recommending we follow the same methodology we did for 'Phase I' and move on:

- Of course, all COHC Board e-votes will be ratified at future meetings

OHA has a deadline of 4.17.2020 for this plan to be submitted.

Please let me know if anyone has any questions/concerns. ***

If you are in agreement with the aforementioned recommendation – please render your vote to me ASAP via return email no later than end of day Monday 4.13.2020.

PacificSource Community Solutions – Central Oregon

TRANSFORMATION and QUALITY STRATEGY

March 2020

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:

Quality Program Structure:
The quality program of PacificSource Community Solutions (PSCS) aligns with our mission, vision, values, strategic goals, and objectives. With this alignment, the quality program works to ensure members have access to high-quality health care that is safe and effective, care that provides a culturally responsive and supportive member experience, and care that produces positive outcomes. The quality program provides a comprehensive structure for organizing, monitoring, communicating, and improving the health and care of PSCS members by addressing the following requirements, best practices, and OHA recommendations:

- Quality Performance Outcomes and Accountability Requirements outlined in the CCO Health Plan Services Contract Exhibit B - Statement of Work - Part 10
- 42 CFR 438.330(a)(b) Quality Assurance and Performance Improvement Program
- OAR 410-141-3200 Outcome and Quality Measures
- Key elements of Oregon's coordinated care model:
    - Best practices to manage and coordinate care
    - Shared responsibility for health
    - Performance is measured
    - Paying for outcomes and health
    - Transparency and clear information
    - Maintain costs at a sustainable rate of growth

PSCS integrates the quality program throughout the organization, with its company values as the foundation:

- We are committed to doing the right thing.
- We are one team working toward a common goal.
- We are each responsible for our customers' experience.
- We practice open communication at all levels of the company to foster individual, team, and company growth.
- We actively participate in efforts to improve our many communities, internal and external.
- We encourage creativity, innovation, continuous improvement, and the pursuit of excellence.

PSCS' internal Quality Improvement Committee (QIC) consists of PSCS staff who work together to provide consistent oversight of clinical and service quality and have accountability for implementing the quality program for the Medicaid, Medicare, Commercial, and Exchange lines of business. The QIC's areas of oversight include new and changing medical, dental, and behavioral technology, clinical policies and programs, member and provider satisfaction reports, quality initiatives, review of clinical care events, and other identified quality concerns. In addition, the QIC reviews and approves strategic initiatives as they pertain to QI programs. As such, the QIC oversees the development of the Transformation and Quality Strategy (TQS) and makes recommendations to the PSCS Executive Management Group (EMG) and Medicaid Leadership Team (MLT) for review and approval.

PSCS' Clinical Quality and Utilization Management Committee (CQUM) is the advisory body for quality, utilization management, appeals and grievances, and performance improvement activities, under the direct authority of the chief medical officer or a designated medical director. Committee members are primary care, behavioral health, dental, and specialty care clinicians from hospital-based practices, private practices, and community health centers in PSCS' provider network. The CQUM Committee is responsible for the following functions:

- Selects and approves guidelines, criteria, and decision-support resources related to clinical criteria and medical necessity.
- Identifies, researches, reviews, and makes recommendations on quality and performance improvement issues, topics, and activities focusing on evidence-based outcomes, health system integration, health improvement, access to preventive services, and cost-effectiveness.
- Initiates and reviews quality and performance improvement projects, including the identification, development, promotion, evaluation, and monitoring of health plan projects.
- Serves as a technical advisory body for clinically relevant quality, utilization, and performance improvement issues.
- Reviews feedback and provide direction on quality improvement monitoring and evaluation.
- Ensures the recusal of committee members from committee activities when conflicts of interest exist.

CQUM meets every other month and at least six times per year, with the expectation that committee members attend two-thirds of scheduled meetings. The QIC receives regular reports on CQUM activities.

Additional committees that support health transformation and quality improvement include the TQS Steering Committee, the Community Advisory Council (CAC), the Provider Engagement Panel, the Quality Incentive Measures (QIMs) Steering Committee, the Behavioral Health Clinical Quality and Utilization Management Committee (BH-CQUM), the Government Operations Committee, and the Cross-Departmental Medicaid Committee.

The development of the 2020 TQS has been a collaborative effort involving multiple departments within PSCS and many external partners, including the CCO's governing board and CAC. The EMG and MLT have ultimate oversight over the TQS and provide adequate resourcing through an annual strategic planning and information technology support process. Additionally, PSCS developed a 2020 TQS project charter, annual work plan, 2020 TQS CAC Engagement Strategy, and a multi-year work plan, which were refined through multiple iterations of review and feedback by internal and external stakeholders. The TQS Steering Committee supports this process through a diverse group of people from multiple departments with specific expertise. Each appointee to the Steering Committee holds a defined role, including project manager, project development coordinator, state liaison, component manager, IT/analytics feasibility manager, TQS report compliance specialist, CCO directors, and an access to care liaison. Each project within the TQS has an assigned project lead who is responsible for the planning, design, and implementation of the project.

The TQS is composed of projects that are representative of PSCS' activities related to health care transformation and quality. The TQS Steering Committee utilized the following resources to identify ongoing or new initiatives in the component areas specified by the Oregon Health Authority (OHA):

- Regional Health Assessment
- Regional Health Improvement Plan
- PacificSource Strategic Plan
- Delivery Service Network Report
- External Quality Review
- OHA's assessment of the 2019 TQS
- CCO 2.0 Health Plan Services Contract

After reviewing these sources and meeting with Medicaid department staff, the TQS Steering Committee identified a shortlist of potential projects for inclusion in the 2020 TQS. Internal stakeholders, including the MLT and QIC, then reviewed the list of project descriptions and provided feedback and approval. The Central Oregon Health Council (COHC), a 501(c)(3) organization and the governing body of PSCS, and the CAC also provided input and guidance on the proposed projects after receiving a presentation from members of the TQS Steering Committee. Next, the TQS Steering Committee incorporated the information from these internal and external stakeholders and began

working with project leads to define the projects fully. Once drafted, the projects underwent a thorough review by the TQS Steering Committee, MLT, IT, and Analytics to assess feasibility, transformational qualities, resource needs, and project scope. Once approved, the project leads finalized their project descriptions for inclusion in the TQS. The MLT, QIC, and COHC board then conducted a final review and approval of the TQS projects.

Beginning in 2020, PSCS implemented a strategy to improve the meaningful engagement of the CAC with the TQS process. The TQS Steering Committee invited the CAC Coordinator, CAC Chair/Co-Chair, and any other interested members of the CAC to quarterly TQS meetings. These meetings provide a high-level overview of TQS projects and reporting responsibilities while providing CAC representatives an opportunity to ask questions about the projects and learn how the CAC might be involved in current or future TQS work.

The TQS Steering Committee will continue to meet throughout the year to manage projects, collect feedback, and address any concerns with the reporting requirements. Quarterly meetings with the project leads will ensure projects are on target for meeting defined deliverables, address any issues or timeline concerns, and inform leads of updates from the OHA. The MLT and QIC will continue to have oversight over the TQS, and receive regular status updates, along with the COHC Board and CAC.

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

The Central Oregon Regional Health Assessment (RHA) and Regional Health Improvement Plan (RHIP) for 2020-2023 used clinical and community linkages in the region to gather community input and identify shared strategic priorities. Due to the high level of CCO and community engagement throughout this process, PSCS utilized the RHIP as a primary reference to identify priorities to address within the TQS.

The RHIP set forth the following priority areas that helped to inform the development of our transformation and quality initiatives:

- Address poverty and enhance self-sufficiency
  - Informs TQS Projects 3 & 6
- Behavioral Health: Increase access and coordination
  - Informs TQS Projects 2 & 7
- Promote enhanced physical health across communities
  - Informs TQS Projects 1, 2, & 5
- Stable housing and supports
  - Informs TQS Project 6
- Substance and alcohol misuse: prevention and treatment
  - Informs TQS Projects 2 & 7
- Upstream prevention: promotion of individual well-being
  - Informs TQS Projects 5 & 6

The TQS Steering Committee members and TQS project leads participate in specialized RHIP workgroups on an ongoing basis that focus on key aspects of the RHIP. The workgroup shares oversight of the project when there is direct crossover between a RHIP workgroup and a TQS project.

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:

The success of PSCS' 2020 TQS depends on our relationships and engagement with diverse community partners. PSCS collaborates with providers and community partners through a community-oriented approach in

everything we do. For example, PSCS collaborates with local health care and social service partners to help address social determinants of health and equity to support our most vulnerable members. In addition, PSCS works collaboratively with providers to support the increased adoption of CLAS Standards, enhance PCPCH Tier levels, and increase members' access to integrated behavioral health services.

Another example of how PSCS partners with community organizations is through the concerted effort to promote oral health integration within primary care settings. PSCS works closely with the COHC to enhance oral health integration and funding for novel integration efforts. In 2019, this workgroup released a request for proposals to provide funding to primary care and behavioral health clinics to support integration of oral health services within primary care settings that will extend into 2020. PSCS also supports these efforts through value-based payments, analytics, and health information technology assistance, along with close monitoring and coaching. As we implement the 2020 TQS projects, our work with providers, community-based organizations, local public health, and community members will remain central in transforming care for our members and the community at large.

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:

In 2020, as a result of CCO 2.0, PSCS expanded its membership from 61,000 members to approximately 220,000 members, with new contracts in the Lane, Marion, and Polk Counties, in addition to our existing contracts in Central Oregon and Columbia Gorge. This growth brings new relationships, increased staff, and a thoughtful strategy to learn about and engage with our new provider and community partners. We have a unique opportunity to test strategies across the state.

PSCS built upon previous years' experience in developing transformative and successful TQS reports to guide the development of the TQS in its new regions. Part of the strategy for developing the 2020 TQS was to align a majority of our TQS projects across our regions to support this period of growth, to create better efficiencies, and to most effectively support members' access to quality health care. Because we recognize each region is unique, we have capitalized on opportunities to implement the TQS projects in regionally specific ways. The implementation of the 2020 TQS will ensure the use of community oriented and culturally responsive interventions to support our members' health and aid in healthcare transformation.

Section 2: Transformation and Quality Program Details

A. **Project or program short title**: Project 1: Improving Access to Care and Monitoring

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

B. **Components addressed**

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

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

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

In 2019, the Provider Network (PN) Department drafted the Medicaid Network Management Policy based on an inventory of existing procedures currently in place around access to care. The new comprehensive Medicaid Network Management Policy provided a single reference for business owners to review and helped to standardize our processes and capture mitigation plans to ensure adequate access to care for our members. Additionally, this Policy outlined the functions of the Access to Care Committee, which PacificSource Community Solutions (PSCS) established to monitor potential gaps in access to care and develop strategies to address these gaps accordingly.

PSCS also developed a platform for compiling site visit questionnaire results regarding access to care. The development and implementation of the Contract Resource Management (CRM) tool provided the PN Department a central location to house, track, and evaluate information gathered from site visits. The completion of phase one of this platform streamlined our ability to analyze data from site visits, and future enhancements will allow us to identify improvement opportunities and inform meaningful access measures to focus on in 2020.

Finally, the PN Department hired an Access to Care Analyst to support PSCS' ongoing work of improving members' access to care. The Access to Care Analyst will be responsible for monitoring and compiling data from the CRM and will provide recommendations to the Access to Care Committee on how to address the gaps identified in the data. By continuing to enhance PSCS' procedures and internal processes around access to care, more members will receive timely, quality care that addresses their cultural and linguistic needs.

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

The PN Department will use the Contract Resource Management (CRM) tool to identify access barriers and develop strategies to improve the Timely Access to Care and the Quality and Adequacy of Services by identifying problems and trends relating to members' access to care. The PN Department will work with providers identified as noncompliant to develop an actionable plan to bring the provider into compliance with our access standards or take appropriate actions if such compliance is not promptly forthcoming.

Additionally, the Provider Access Analyst will evaluate cross-functional data relating to access to identify gaps and develop targeted interventions to improve members' access to care. The Provider Access Analyst will collaborate with the Access to Care Committee and the Business Intelligence Department to create access measures for monitoring and analysis. The findings and conclusions drawn from monitoring the selected access measures will be documented in a comprehensive annual report to inform strategies to improve members' access to care.

Finally, PSCS will partner with SPH Analytics to develop and deploy an access to care survey to monitor members' experience receiving care, including the timely, and quality and adequacy of care they receive, and whether providers

meet members' Cultural Considerations and linguistic needs. The Access to Care Committee will review the 2020 data and recommend interventions as appropriate.

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

Activity 1 description: PN will continue to enhance the internal CRM tool with the intent of improving its ability to collect actionable and meaningful data to capture access needs for Medicaid members.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Utilizing the CRM tool, PN will identify opportunities to improve standards related to Timely Access to Care and the Quality and Adequacy of Services and develop strategies for monitoring the provider's adherence to access standards.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Site visit questionnaire and site visit evaluation data is stored within the CRM tool so that the PN Department can analyze the results of each site-visit regarding access to care.	Develop a strategy to review site-visit findings and implement an action plan to assist noncompliant providers in being compliant with PSCS' access to care standards.	06/2020	Monthly monitoring of the site review data collected in the CRM tool and development of an action plan for providers found noncompliant with PSCS' access standards. Action plan will include targeted interventions for providers to implement to become compliant, with identified timelines for completion and corresponding consequences.	12/2020

Activity 2 description: Develop a system of tracking and monitoring access to care. Identify gaps and report findings to the Access to Care Committee to improve access and barriers.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: The Provider Access Analyst will evaluate internal access data and produce an Access Monitoring Review Report, which will identify trends and gaps in access to care. The Access Monitoring Review Report will be used to formulate recommendations to improve members' access to care to the Access to Care Committee.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Provider Access Analyst hired to ensure routine access monitoring and reporting and to develop and implement processes to continually improve access to care.	Collaboration with Access to Care Committee and Business Intelligence Department to develop access measures that PSCS will monitor, analyze, and interpret.	09/2020	Produce a comprehensive annual Access Monitoring Review Report of the findings from monitoring access measures and provide updates and results to the Access to Care Committee once per quarter.	12/2020

Activity 3 description: Develop and deploy a member survey to measure and monitor members' ability to get timely and culturally competent care across regions and service lines.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Measure member experience accessing care that is timely and meets the members' cultural and linguistic expectations, to develop baseline metrics and inform interventions.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
While PSCS has taken action based on historic CAHPS results, PSCS does not currently administer a member survey to measure experience accessing care.	PSCS administers a member survey to measure experience accessing care.	06/2020	Access to Care Committee reviews 2020 member survey data and recommends 2021 interventions.	12/2020

A. **Project or program short title**: Project 2: PCPCH Enhancement and Financial Support

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): Behavioral health integration
iii. Component 3 (if applicable): Health equity: Data
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**:

"Increasing behavioral health access and support" remains a high priority within the 2019 Regional Health Assessment (RHA). In Central Oregon, "approximately one in four adults over 55 years of age reported a diagnosis of depression, and 50% of adults with diabetes also reported depression." Although primary care is available for direct access by any CCO member or community member, behavioral health access remains an issue. Patient-Centered Primary Care Home (PCPCH) and Behavioral Health Integration (BHI) are linked models designed to deliver holistic care within one setting and ensure that members receive the right care in the right place at the right time. This project supports PCPCH clinics and members receiving behavioral health services within primary care by promoting BHI within PCPCHs and assisting clinics with successfully meeting the intent of Standard 5C3: Behavioral Health Integration, as currently written within the 2017 PCPCH Technical Specifications. This project builds on and fine-tunes prior years' work in which PacificSource Community Solutions (PSCS) provided financial support and technical assistance (TA) to implement high-value PCPCH and BHI elements in primary care clinics that serve our members. At the end of 2019, over 90% of Central Oregon CCO members were served in a fidelity-based BHI primary care home that achieved a minimum population reach metric.

Two of the significant barriers to adoption of these models are (1) the lack of financial support for the non-encounterable elements of the work and (2) the need for TA to assure that clinics are implementing the models with fidelity. In 2020, to address these barriers, we will move from a grant-based financial model to a contractual value-based payment (VBP) model using a per-member-per-month (PMPM) payment for delivery of the program to fidelity. The quality component of the program requires clinics to report on three population metrics to assess progress towards outcomes. By continuing to offer and expand meaningful support, PSCS is working to increase access to behavioral health services and expand the population reach of integrated services provided by behavioral health clinicians (BHCs), with the ultimate goal of improved health care outcomes across the population.

This project raises the bar for increased access to behavioral health services for our members. Facilitated conversations, in the form of learning collaboratives, will assist PCPs and BHCs in strengthening their support for our members by creating a shared understanding on how to engage our members in integrated behavioral health services. Furthermore, PSCS plans to continue work with the Health Council and to provide TA to support providers participating in the BHI VBP program, as well as those developing integrated care models who wish to participate in the program in the future. In 2020 and beyond, PSCS will begin to build the infrastructure needed to provide TA and learning collaboratives to implement other advanced PCPCH measures outside of BHI, and will also take steps to advance our member assignment logic to account for increased PCPCH tier status.

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

PSCS will provide financial support and TA to implement high-value BHI elements in PCPCHs that serve our members. For clinics to participate in the fidelity-based BHI program, they must be at least a Tier 3 PCPCH, and the delivery of financial support is via a PMPM tied to a VBP model. Each participating clinic is required to submit quarterly reports consisting of three metrics, including the population reach metric. TA will be available to CCO providers to support effective BHI via annual site visits or documentation review. TA will also include learning collaboratives, trainings, meetings, individual

clinic support, and/or facilitation of Community of Practice meetings. Program goals include increasing program participation, increasing population reach by 5% each year, and offering TA focused on improving collaboration and coordination between PCPs and BHCs.

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

Activity 1 description: PSCS will offer continued and expanded support for the implementation of fidelity-based BHI in PCPCHs using a VBP strategy, which requires a minimum population reach of 5% for the first year of participation and 10% for clinics in the second year of the program.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: We will monitor (1) fidelity of program and expansion of the program model through clinic attestations with follow-up site visits and/or documentation reviews, and (2) quarterly data reporting on population reach, with targets that are commensurate with the clinic's maturity in the program.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
0% of PCPCH clinics are currently enrolled in VBP arrangements for the PCPCH model of BHI.	>66% increase in the number of PCPCHs that are enrolled in VBP arrangements for BHI.	12/2020	>66% increase in the number of PCPCHs that are enrolled in VBP arrangements for BHI.	12/2020
Over 66% of PCPCHs that participated in the 2019 VBP BHI Program achieved a 10% population reach.	>80% of participating clinics achieve 10% population reach.	12/2020	>80% of participating clinics achieve 10% population reach.	12/2020

Activity 2 description: PSCS will offer support to PCPCHs by providing TA via learning collaboratives to increase collaboration between primary care and specialty behavioral health and increase access and coordination.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: We will monitor progress in TA focus areas through (1) collaborations between PCPCHs and specialty behavioral health providers, and 2) deploying Behavioral Health Population Strategists and Behavioral Health Coaches to enhance clinic workflows and integration practices.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Three Building Bridges trainings have occurred, focused on increasing BH access and collaboration between PCPCHs and specialty behavioral health providers.	Cumulatively, six or more Building Bridges trainings will have occurred.	12/2020	Cumulatively, six or more Building Bridges trainings will have occurred.	12/2020

No TA is currently being provided to PCPCHs on analyzing their population reach with a health equity lens.	Each participating PCPCH clinic will be offered TA to begin analyzing their population reach data by language spoken and/or race and ethnicity.	12/2020	100% of participating clinics will report population reach by race and ethnicity on a quarterly basis, and create plans for addressing adverse differences.	12/2021

Activity 3 description: PSCS will begin to plan and build the infrastructure needed to support the implementation of advanced PCPCH measures.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: PSCS will begin to plan and build the infrastructure needed to support the implementation of advanced PCPCH measures through meetings with providers and community partners.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Population Health team has not met with provider partners to conduct a needs assessment for PCPCH TA.	Population Health team meets with provider partners to conduct needs assessment for PCPCH TA.	09/2020	TA is developed in collaboration with provider partners to implement advanced PCPCH measures.	01/2021

A. **Project or program short title**: Project 3: Advancing CLAS Standards with a focus on Language Access and Implicit Bias Training

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

B. **Components addressed**

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

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

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

PacificSource Community Solutions (PSCS) is in the process of operationalizing the state-adopted definition of health equity developed by the Health Equity Committee, a sub-group of the Oregon Health Policy Board:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistributing of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

In the spirit of this definition, PSCS' 2018 and 2019 Health Equity Transformation and Quality Strategies (TQS) sought to:

- Improve PSCS' internal and external-facing operations to promote Culturally and Linguistically Appropriate Services (CLAS).
- Deepen understanding of CLAS Standards within the broader provider network to enhance service delivery to meet the needs of a diverse population.

To achieve this, PSCS implemented several improvements and stakeholder engagement activities. As a result of the TQS efforts, PSCS included the following language in all provider contracts:

> *Providers shall meet the National Standards for Culturally and Linguistically Appropriate Services (CLAS) by providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural beliefs and practices, preferred languages, health literacy, and other communication needs.*

Other improvements from PSCS' 2018 and 2019 projects include:

- Provider site-visit assessments included questions on interpreter quality and access, as well as cultural responsivity training.
- PSCS introduced cultural responsivity training (Quality Interactions' ResCUE Model™) mandated for all employees, across all lines of business. Completion rate for this course was 95%, and this training is now standard for all new employees.
- PSCS developed a provider incentive model for Diversity, Equity, and Inclusion training, to launch in 2020.

PSCS' work over the past TQS cycles has had an impact that reaches beyond specific TQS goals or benchmarks. The company has enhanced its policies and created a Language Access Plan (LAP) related to serving a culturally and linguistically diverse membership and has adopted CLAS Standards enterprise-wide. While we have made strides in

promoting CLAS in our company and provider networks, we are committed to improving services where we have identified community gaps and needs. In the fall of 2019, PSCS conducted a series of community listening sessions across each of our CCO contract regions to inform our health equity planning. A preliminary review of the qualitative data highlighted the need to develop specific actions that will address access and quality of language assistance services. In addition, the need for training on the topic of implicit bias was a significant and crosscutting theme.

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

PSCS' 2020 Health Equity TQS project will continue to advance CLAS Standards both internally and amongst our network of providers. Our focus areas include:

- Language access and quality (CLAS Standards #5-8), as a vehicle to implement key action steps outlined in PSCS' Language Access Plan (LAP).
- The introduction of implicit bias training for PSCS employees as well as providers and subcontractors (CLAS Standards #4).

This project outlines new activities within CCO Analytics, Communications, Human Resources, and Provider Network Department processes related to these two community-identified needs. In addition to advancing CLAS Standards, activities will address the following components:

Access: Cultural Considerations: This project will facilitate improvements in language access for limited English proficiency (LEP) and deaf/hard of hearing members, as outlined in PSCS' LAP. Activities will focus on:

- Promotion of the CCO's LAP network-wide, to support broad adoption of related policies and practices (CLAS Standard # 13).
- Introduction of contractual requirements to providers, asking that they submit written language access policies and procedures that are updated annually (CLAS Standard #10).
- Monitoring of the quality of interpretation vendors (CLAS Standard #7).
- Development of lobby posters and "I Speak" cards to establish a method for patients to self-identify preferred languages when needing assistance (CLAS Standard #8).

The 2019 project introduced a method of tracking active provider policies related to CLAS Standards through provider site-visit surveys. The 2020 project will focus on establishing a data workflow for ongoing monitoring, and technical assistance needs assessment. Additionally, we will assess community resource capacity and existing contracts for the adequacy of language assistance services. In addition, we will utilize race, ethnicity, age, language, and disability (REAL+D) data and other sources to:

- Identify providers that serve a significant number of LEP and deaf/hard of hearing individuals who may benefit from developing new procedures and practices proven to enhance the provision of more efficient language assistance services (CLAS Standard # 11).
- Identify and address gaps where in-person language assistance services may be inadequate to meet the need (CLAS Standard #11).

Health Equity: Cultural Responsiveness: In 2019, PSCS introduced its employees to an online course by Quality Interactions, Inc. (QI) called *ResCUE Model™ for Cross-Cultural Communication.* This training provided valuable concepts and skills related to interacting with diverse populations. Course completion rates throughout the organization exceeded our TQS benchmark. In 2020, PSCS will expand this initiative further by adding implicit bias training by QI for all employees. In addition, PSCS will offer cultural responsivity and implicit bias training to providers and subcontractors who do not have cultural competency training resources available in-house or whose resources do not meet the OHA's requirements (CLAS Standard #4).

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

Activity 1 description: Access: Cultural Considerations: Advancing language access plans, policies, and procedures network-wide; improving processes at PSCS to enable members to self-identify language assistance needs.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PSCS will distribute its LAP and related policies to providers and subcontractors through at least two channels and measure distribution to estimate impact; require providers to submit policies and/or procedures related to language assistance.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Zero providers have seen PSCS' LAP.	PSCS will distribute the LAP through at least two channels.	5/2020	At least 75% of contracted providers will have received PSCS' LAP through one of two channels.	12/2020
Currently, providers are not required to submit policies and procedures related to Language Access.	PSCS will include the requirement that providers submit policies and procedures in the CCO provider manual.	12/2020	PSCS will include the requirement that providers submit policies and procedures in the CCO provider manual.	12/2020

Activity 2 description: Access: Cultural Considerations: Monitoring access and quality of interpreter services.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PSCS will operationalize qualitative assessments of members to measure quality and access of language assistance services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PSCS has not implemented a member survey to measure members' experience of the quality and access to interpreter services.	PSCS will implement a member access survey and produce a report on results.	06/2020	Survey results will be analyzed to inform Health Equity Plan and LAP updates.	12/2020

Activity 3 description: Member self-identification of preferred language.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Access: Cultural Considerations: PSCS will develop "I-Speak" cards and signage to establish a method for members to self-identify preferred languages when needing assistance (CLAS Standard #8).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PSCS does not offer or promote "I-Speak" cards or signage.	PSCS will develop at least two "I-Speak" materials (cards, posters) and establish a strategy for deployment to members and providers.	06/2020	PSCS will offer "I-Speak" cards to offices serving CCO members in the region. Providers will receive digital versions of cards and posters through at least one channel.	12/2020

Activity 4 description: Access: Cultural Considerations: Establish a data workflow for ongoing monitoring and technical assistance needs assessment to inform annual updates of PSCS' LAP.

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: PSCS will utilize REAL+D data and other sources to identify providers serving LEP individuals. PSCS will use data to update its LAP annually and identify providers who may benefit from technical assistance (e.g. support for developing a LAP and/or policies and procedures for language assistance services).

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PSCS has not completed an analysis of language assistance needs.	PSCS will collect and analyze REAL+D data overlaid with provider attribution data to assess language assistance needs at the point of care and produce one report.	08/2020	PSCS will identify at least one provider where language assistance needs are evident and offer technical assistance.	12/2020

Activity 5 description: Health Equity: Cultural Responsiveness: Implement Implicit Bias training to PSCS employees and offer to providers and sub-contractors.

☒ Short term or ☐ Long term

Monitoring activity 5 for improvement: PSCS will track training participation rates to inform future continuous improvement strategies.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PSCS has not trained its employees explicitly on implicit bias.	At least 90% of PSCS employees will complete implicit bias training.	12/2020	At least 90% of PSCS employees will complete implicit bias training.	12/2020

PSCS does not currently offer cultural responsivity or implicit bias training tools to providers and subcontractors.	PSCS will embed cultural responsivity training (ResCUE Model™) for providers to access via provider portal and will promote via at least two channels.	06/2020	PSCS will embed implicit bias training for providers to access via provider portal; promote training via at least two channels.	12/2020

A. **Project or program short title**: Project 4: Monitoring of CCO and Subcontractor Grievance and Appeals Data

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

B. **Components addressed**

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

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

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

The 2019 Grievance and Appeal System project enhanced the use of grievance and appeals data by developing dashboards to measure and identify trends related to access. The results identified dental access and member satisfaction with provider services as areas of opportunity. Additionally, quarterly analyses identified a need to focus on transportation and the quality of services provided to members. Internal departments then reviewed the evaluation of access data in order to address these areas of concern.

In 2020, the Appeals and Grievances (A&G) Department will continue to share access data to support continuous improvement efforts. The conclusion of last years' project made apparent the need to formalize more frequent and routine monitoring of member complaints and complaint-resolution by subcontractors, as well as to provide support in implementing initiatives to improve processes. This year's project will focus on monitoring trends to establish better processes and escalation paths to implement needed improvements, both within the CCO and among our subcontractors.

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

This project will establish a standardized tool for monitoring internal grievance and appeals data and all subcontractors performing complaint resolution. The monitoring tool will collect information on the CCO's and subcontractors' handling of appeals and grievances. The CCO will evaluate delegated processes allowed by contract and review this data for an appropriate response to an appeal and grievance, the timeliness of responding to member complaints, and whether the CCO and subcontractor followed the correct appeals and grievances processes and criteria for addressing an appeal or grievance. Based upon the data collected and analyzed from this tool, PacificSource Community Solutions (PSCS) will initiate a minimum of one intervention per subcontractor and one at the CCO to improve processes or services to support timely, accurate, and compliant responses to appeals and grievances. The Medicaid Regulatory and Reporting Specialist will use monthly logs submitted by subcontractors performing appeal and grievance activity, as well as internal data, to assess process requirements and opportunities for improvement. The Specialist will use this data, trended month over month, to collaborate with subcontractors and internal staff on improvement activities.

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

Activity 1 description: To support the ongoing analysis of grievance and appeals data and to monitor subcontractors' complaint resolution timeliness and consistency, PSCS will develop a tool to support these initiatives.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PSCS will develop a standardized monitoring tool to analyze grievance and appeal data and subcontractors' complaint resolution processes. The monitoring tool will be updated monthly and analyzed by the Medicaid Regulatory and Reporting Specialist.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No standardized monitoring tool for grievance and appeals data exists.	Tool developed, approved, and implemented at the CCO and among subcontractors.	06/2020	Monitoring tool is updated monthly, saved to the A&G SharePoint site, and submitted to Compliance on a monthly basis.	12/2020

Activity 2 description: PSCS will develop one intervention with each subcontractor, to be determined based upon monitoring analysis, and one intervention across the entire spectrum of membership that improves processes or services to members.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PSCS will monitor and analyze A&G data, including category trends found on the OHA quarterly report, on a monthly basis using the new monitoring tool. Based on the analysis, A&G will develop interventions to address identified issues.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
A&G currently monitors grievance and appeals data on a quarterly basis.	A&G monitors and analyzes data affecting timeliness, access, and other category trends listed on the OHA quarterly report on a monthly basis.	06/2020	Trends are identified by subcontractor and by the CCO, to develop interventions, if warranted.	12/2020
A&G currently reviews appeals and grievance data, but has not developed interventions based on the new monitoring tool.	A&G develops one intervention per subcontractor, if warranted, and one within the CCO with defined expectations.	12/2020	A&G develops one intervention per subcontractor, if warranted, and one within the CCO with defined expectations.	12/2020

A. **Project or program short title:** Project 5: Diabetes: Interprofessional Care Collaboration between Primary Care and Dental Providers

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**:

Diabetes prevalence and its impact on health is a concern throughout PacificSource Community Solutions' (PSCS) CCO regions. Data presented in the 2020-2023 Central Oregon Regional Health Improvement Plan (RHIP) indicates that "diabetes is more prevalent among adults overall in Central Oregon than Oregon as a whole." Optimal disease management and prevention remain a top priority for PSCS, given the continued impact of diabetes across the state and throughout Central Oregon.

Preventing or correcting oral diseases is part of optimal diabetes management. Yet, dental providers are frequently unaware of their patients' chronic conditions prior to them seeking care, and often have no source of health status information beyond a patient's report. Such knowledge is critical in determining appropriate courses of treatment, as well as prompting referrals to primary or specialty care for further treatment when necessary.

In addition, physical health providers frequently do not address oral health with their patients, nor do they typically have information regarding their patient's dental care provider or oral health history. The current state of health information technology is an impediment to a broader view of a patient's overall health, as well as effective coordination of care. For these reasons, many patients with diabetes do not establish consistent care with a dental provider, and as a result, do not receive the coordinated, integrated, and specialized care they need.

In 2019, PSCS created the *Dental Care for Diabetics* report and deployed it to participating physical health providers, who also received other PSCS care coordination reports. This report provides information to primary care physicians (PCPs) and clinics on their panel's rate of dental visits, including periodontal or prophylaxis visits, which enables them to integrate oral health into their patients' overall care. In the fall of 2019, PSCS began familiarizing providers with the report, including desired referral actions to dental providers. Given the low dental utilization rate among adults with diabetes, PSCS will continue promoting provider understanding and use of analytics tools such as the *Dental Care for Diabetics* report and will deploy the report in the Lane and Marion–Polk regions in 2020.

Another promising strategy is to deliver dental services at the location where the patient is receiving their primary care via teledentistry. Teledentistry is the coordination and delivery of dental care (diagnostic, preventative, and some treatment) using electronic, video, and audio technologies that transmit patient data to the remotely located treating dentist via a dental hygienist, who is physically with the patient. Using video conferencing and other live communication technologies, a live virtual visit between the patient, hygienist, and dentist can occur. Alternatively, dental providers can view patient information later in a "store-and-forward" visit.

This model has many benefits, such as reducing patient burden and abrasion, increasing care utilization, and reducing delivery system burden. In Oregon, the delivery of comprehensive care via co-located teledentistry is still emerging but is delivering promising results at piloted physical health locations treating diabetic patients. PSCS plans to continue working with Dental Care Organizations (DCOs) to expand the co-location of teledentistry to primary and specialty care clinics as a strategy for increasing dental utilization and interprofessional collaboration for the diabetic population.

Additional work from PSCS' 2019 TQS projects included efforts to increase adoption of the Reliance eReferrals platform and Community Health Record. The eReferral platform provides a single, closed-loop referral system usable by any provider type, regardless of the current Electronic Health Record (EHR) and messaging technologies. The Community Health Record allows a provider to access important clinical information such as problem lists, medication lists, and visit history. Utilization of these types of tools allows effective communication between dental and physical health providers, which improves collaboration and coordination of care.

In 2019, Advantage Dental adopted the eReferrals technology, and Capitol Dental began the implementation process. However, ongoing delays with Reliance's planned platform updates prevented any further adoption in Central Oregon by physical health providers, which impeded efforts to increase interprofessional referrals using Health Information Technology (HIT). Furthermore, the adoption rate of the Reliance Community Health Record in Central Oregon has remained relatively unchanged since the inception of this TQS project.

PSCS anticipated that increased adoption and use of these Health Information Exchange (HIE) functions would support current community-driven work to jumpstart oral health integration in primary care settings. The project, funded by the Central Oregon Health Council (COHC), is a two-year (2019-2020) pilot within two health systems and a specialty practice to implement DentaQuest's MORE Care model. This model uses an integrated approach to increase the availability of preventative oral health services from primary care physicians. In addition, it encourages referrals between physical health and dental care providers and promotes interprofessional collaboration. The delay with Reliance is negatively impacting referral closure rates and bidirectional communication. Primary care clinics and DCOs are currently relying on manual, time-consuming methods such as emailing or faxing forms and spreadsheets. Despite these ongoing challenges, the COHC's recently published 2020-2023 RHIP has identified several improvement strategies specific to interprofessional, cross-system collaboration, care coordination, and adoption of HIT tools such as closed-loop referral platforms. Therefore, PSCS will continue to partner in advancing this work to align with regional priorities and strategies.

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

In an effort to implement and improve Oral Health Integration, PSCS will continue using a Value-Based Payment model (VBP) to incentivize the delivery of dental care to members with diabetes. This work aligns with the quality incentive measure (QIM) addressing oral evaluations for diabetic members and continues tracking with the 2019 TQS strategy to use VBP to incentivize each DCO to achieve performance improvement targets and, ultimately, the region's performance benchmark on this measure. The VBP strategy, in combination with monthly monitoring and sharing of measure dashboards and gap lists, will help drive continued progress.

PSCS will also promote the establishment and expansion of co-located teledentistry programs within physical health clinics, to increase dental care utilization in the diabetic population.

Finally, PSCS will continue promoting the adoption of Reliance's eReferrals platform and Community Health Record. Adoption of an eReferrals platform will enable interprofessional collaboration and care coordination between physical and dental providers, while the Community Health Record will facilitate access to important clinical patient information such as problem lists, medication lists, and visit history.

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

Activity 1 description: Leverage VBP strategies, dashboards, and monthly monitoring to increase the percentage of diabetic members who receive a comprehensive or periodontal exam during the measurement period.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitoring will occur via a dashboard that displays year-to-date performance on diabetic members with dental visits. This dashboard (accompanied by a gap list) will be refreshed monthly and shared with each DCO.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CCO estimated baseline for the region overall and each contracted DCO: Regional: 30.5% Advantage: 30.7% Capital: 32.3% ODS: 33.6%	OHA-stipulated improvement target for CCO/each DCO is determined by OHA in June 2020, and PSCS dashboards are updated to reflect the improvement target.	06/2020	CCO performance meets benchmark of 26.8% and all DCOs perform at or above this level.	12/2021
	The CCO and each DCO meets the CCO improvement target.	12/2020	The CCO and each DCO meets the CCO improvement target.	12/2020

Activity 2 description: Promote dental care delivery to the diabetic population via teledentistry, co-located with physical health provider clinics.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Initial monitoring will occur via a regional DCO survey to establish baseline for co-located teledentistry models in each region. Improvements to baseline will be monitored quarterly to track growth in teledentistry activities/partnerships.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No dental integration activities tracking log exists to present a comprehensive picture of integration efforts in Central Oregon (including teledentistry).	A dental integration activity tracking log is created and updated periodically to present a comprehensive picture of integration efforts (including teledentistry).	03/2020	A dental integration activity tracking log is created and updated periodically to present a comprehensive picture of integration efforts (including teledentistry).	03/2020
Baseline availability of co-located teledentistry programs serving the diabetic population is established using the tracking log data.	1 or more co-located teledentistry programs are serving the diabetic population.	12/2020	2 or more co-located teledentistry programs are serving the diabetic population.	12/2021

Activity 3 description: Work with various internal and external regional stakeholders to encourage adoption of the Reliance HIE eReferrals platform and the Community Health Record to enable care coordination and interprofessional collaboration. Subsequent to the release of the updated eReferrals platform, facilitate product awareness by arranging demonstrations (as needed) of the updated platform and Community Health Record to provider clinics and groups.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: The CCO will track a number of measures of improvement: number of dental clinics, DCOs, and physical health clinics enrolled with the Reliance eReferrals platform and Community Health Record and the number of eReferrals generated by dental clinics and physical health clinics.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Number of organizations enrolled with the Reliance eReferrals platform: 0 dental clinics 1 DCO 0 physical health clinics	Number of organizations enrolled with the Reliance eReferrals platform: 2 dental clinics 2 DCOs 3 physical health clinics	12/2020	Number of organizations enrolled with the Reliance eReferrals platform: 6 dental clinics 3 DCOs 6 physical health clinics	12/2021
Number of organizations enrolled with the Reliance Community Health Record: 0 dental clinics 0 DCOs 3 physical health clinics	Number of organizations enrolled with the Reliance Community Health Record: 2 dental clinics 2 DCOs 5 physical health clinics	12/2020	Number of organizations enrolled with the Reliance Community Health Record: 4 dental clinics 3 DCOs 8 physical health clinics	12/2021
0 referrals generated electronically by dental clinics and sent to physical health clinics.	20 referrals generated electronically by dental clinics and sent to physical health clinics.	12/2020	40 referrals generated electronically by dental clinics and sent to physical health clinics.	12/2021
0 referrals generated electronically by physical health clinics and sent to dental clinics.	20 referrals generated electronically by physical health clinics and sent to dental clinics.	12/2020	40 referrals generated electronically by physical health clinics and sent to dental clinics.	12/2021

A. **Project or program short title**: Project 6: SDOH-E Screening, Referral and Navigation

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): Health equity: Data
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 healthcare industry is reaching a tipping point of awareness on how social determinants influence a person's overall health, yet these social needs continue to remain largely undetected and unaddressed. In an effort to close this gap, a growing number of health centers, emergency departments, and health plans are beginning to screen their patients for Social Determinants of Health and Equity (SDOH-E). From this movement, models are emerging to support community-based referrals and navigation to help meet the health-related social needs of individuals and communities. PacificSource Community Solutions (PSCS) aims to support this momentum by promoting standardized SDOH-E screening processes at a systems level and advancing infrastructure to reinforce connections between healthcare and community social needs services. To achieve this, we will focus our efforts on supporting a shared framework through screening tools, information sharing between clinical and social service agencies with shared populations, and utilizing best-practice methods for stratifying social risk.

PSCS' 2018 and 2019 SDOH-E Transformation and Quality Strategy (TQS) projects sought to advance clinical and community linkages through participation in the Oregon Accountable Health Communities (AHC) study, the Center for Medicare and Medicaid Innovation Center grant (Central Oregon), and the Bridges to Health Pathways program (Columbia Gorge). These programs provide screening, referral, and navigation services to address health-related social needs. Their ultimate goal is to improve health outcomes and reduce the cost of care by creating community-wide support for the highest needs residents. The project components include:

- Implementing SDOH-E screening to identify health-related social needs, such as housing, food, utilities, transportation, and interpersonal violence.
- Connecting patients to community services.
- Developing a tailored referral and care plan where needs are indicated.

In 2019, 635 PSCS' members were screened for SDOH-E as part of the AHC Initiative. Results showed that 60% of those screened had an unmet social need. PSCS is interested in continuing to support these initiatives by establishing streamlined workflows at the CCO level, which would align with screening, referral, and navigation practices that are occurring in clinical and community health settings.

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

In 2020, PSCS will leverage lessons learned from the AHC Initiative and Bridges to Health Pathways program by internally operationalizing SDOH-E screening, referrals, and navigation, and utilizing the care management workforce, including its team of personal health navigators. This data-informed TQS project focuses on the following components:

Social Determinants of Health and Equity

- CCO screening of members using a standardized screening tool embedded in Clara Vistalogic™, an integrated technology platform, used in the AHC project.
- Connecting patients with social risk factors to a community resource tool, such as 211's Community Resource Summary.

- Providing navigation for persons who screen positive for one or more social needs to community agencies and resources.

Health Equity: Data

- Analyzing internal screening, referral, and navigation data by demographic and risk strata, to inform efforts to advance Health Equity.
- Analyzing external screening, referral and navigation data received from the AHC project to inform efforts to advance Health Equity.
- Development of data staging and integration with member risk profiles.

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

Activity 1 description: Social Determinants of Health and Equity: PSCS will identify a mechanism to advance screening of members for SDOH-E using a standardized screening tool and connect members to community resources.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PSCS will monitor screening, referral, and navigation rates using a new tool linked from the existing Case Management (CM) platform, Dynamo.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CM uses a tool built into their tracking system (Dynamo) to screen members for SDOH-E.	Embed a link in Dynamo to connect CM to the standardized AHC screening tool in Clara Vistalogic™.	06/2020	CM has access to a Community Resource Summary, developed by 211 and OHSU; CM offers summary to at least 50% of members who screened positive for a social need.	12/2020
CM follows up with members who screen positive for SDOH-E and manually inputs data into Dynamo.	CM provides navigation for members who screen positive for SDOH-E and referral information is tracked using the Clara Vistalogic™ system.	06/2020	40% of members who screen positive for SDOH-E are offered navigation to services.	12/2020

Activity 2 description: Social Determinants of Health and Equity: Analyze internal and external screening, referral, and navigation data by demographic and risk strata, to inform future efforts to advance Health Equity and evolve PSCS competencies to integrate member social needs with population risk profiles.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PSCS will monitor screening data by race, ethnicity, age, language, and disability (REAL+D) demographics for this CCO region to identify prevalent social needs of our membership, and establish data staging and reporting to inform member risk profiles.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Currently, there is a manual process for receiving AHC screening, referral, and navigation data, collected via Clara Vistalogic™.	Establish a secure file transfer protocol (SFTP) site to receive weekly data feeds of AHC data.	06/2020	Develop data staging workflows and build at least one standard report template of social need risk among CCO membership, disaggregated by REAL+D where data exist.	12/2020
Currently, there is no method of integrating social risk with medical risk in PSCS' risk profile reporting.	Develop plan for social risk stratification that can be used by CM to triage members into the best match interventions.	12/2020	Develop plan for social risk stratification that can be used by CM to triage members into the best match interventions.	12/2020

A. **Project or program short title**: Project 7: Utilization of Direct Access to 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): Special health care needs
iii. Component 3 (if applicable): Serious and persistent mental illness
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 2019, PacificSource Community Solutions (PSCS) focused on working directly with clinics to enhance workflows to reduce Emergency Department (ED) utilization among members with Serious and Persistent Mental Illness (SPMI). In Central Oregon, we identified Deschutes County Behavioral Health (DCBH) and the Harriman Clinic (HC), part of Mosaic Medical, which is a fully integrated primary care clinic, to pilot workflows using Health Information Technology (HIT) to impact ED utilization among the SPMI population. PSCS made considerable progress in fulfilling the goals identified in this project. Though we did not fully complete all of the objectives by the end of 2019, we were able to accomplish our goal to support DCBH in the development of a shared workflow and standardize how they respond to the information they receive from HIT. We were not able to complete Activity 4, which involved developing a baseline to measure the impact of the shared workflows and targeted interventions moving forward. Although we intend to close out the 2019 ED utilization among members with SPMI project, PSCS plans to enlist the support of our new Behavioral Health Performance Coach to continue to support this work in 2020.

To identify opportunities to enhance support for members with SPMI, PSCS plans to focus our efforts on affecting the SPMI component more broadly. By incorporating the SPMI component into a project that addresses Utilization Review and Special Health Care Needs (SHCN), we anticipate gaining a better understanding of the under- and over-utilization of direct access for specialty care services for members with SHCN and SPMI.

There is a significant overlap in our prioritized populations identified for Intensive Care Coordination (ICC) services among members with SHCN and SPMI. As outlined in OAR 410-141-3870, a prioritized population includes members identified as having complex or high health care needs, multiple or chronic conditions, SPMI, or receiving Medicaid funded Long-term Care Services and Supports (LTSS). Therefore, PSCS uses the prioritized population definition, and more broadly, the ICC population, to evaluate the utilization of specialty care services for members with SHCN and SPMI.

PSCS aims to increase equitable access to skilled and coordinated care between specialty care and the broader health system while decreasing barriers to ensure adequate care and positive health outcomes for those we serve. Members who belong to prioritized populations, such as those with SHCN or SPMI, often fail to receive the proper specialized health care they need to manage their conditions. Currently, PSCS does not track or know the direct access utilization of specialty care services specific to the ICC population. However, the Case Management Department does attempt to contact all members identified for ICC services via letter and telephonically to engage in services. In doing so, members are educated on the benefits of ICC including direct access to specialty services. By monitoring direct access, PSCS will establish a baseline for members' utilization of specialty care services and aim to address areas of under and over-utilization of specialty services.

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

PSCS will develop a mechanism to report the utilization of direct access to specialty care for members identified as ICC eligible, which encompasses members with SHCN and SPMI. PSCS will use multiple data sources to improve ICC identification and establish workflows between Care Management and Utilization Management Departments. The goal of this process is to allow our Care and Utilization Management Departments to understand ICC members' direct access to specialty care services within each region. Based on the results of this project, in 2021, PSCS intends to increase the direct access to specialty care by educating ICC members who are not utilizing this benefit.

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

Activity 1 description: Currently, PSCS utilizes multiple data sources to identify ICC members. The various data sources need to be refined and consolidated to develop reporting, and monitoring logic for ICC identified members.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PSCS will refine and improve ICC logic identified through care management, claims, and enrollment files, and additional data sources. This improved method of identification will better identify ICC members and consolidate reporting from multiple data sources.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PSCS uses multiple data sources to identify ICC members. Logic for identification needs to be refined and improved.	Refined ICC logic better identifies members for ICC and consolidates identification flags based on care management and claims/enrollment and additional data sources.	09/2020	Refined ICC logic better identifies members for ICC and consolidates identification flags based on care management and claims/enrollment and additional data sources.	09/2020

Activity 2 description: Currently, no reporting exists for monitoring the utilization of direct access to specialty care for ICC members (SHCN and SPMI). The goal of this activity is to develop logic to help identify "direct access" for specialty care services for ICC members to enable future reporting.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PSCS will develop logic and specifications that identify direct access to specialty care services for members within the ICC population.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current method exists to push lists of ICC-identified members (per 2020 OARs) into the claims	Produce a monthly report of identified ICC members to be loaded into the claims processing	09/2020	Produce a monthly report of identified ICC members to be loaded into the claims processing	09/2020

processing system to permit direct access.	system to permit direct access.		system to permit direct access.	

Activity 3 description: PSCS will utilize the identification mechanism developed in Activity 2 to produce a report on the utilization of direct access to specialty care for ICC members. This report will help develop an understanding of utilization patterns that can further aid in creating a strategy to increase the use of this benefit and provide valuable information related to the demographic makeup of those utilizing the benefit.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: PSCS will create a report for ICC members' utilization of direct access to specialty care services and will use this report to develop strategies in Q1 2021 to increase ICC members' utilization of specialty care services if indicated.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
There are currently no reports on ICC members' utilization of direct access to specialty care.	Establish a report that analyzes ICC members' utilization of direct access to specialty care.	12/2020	Establish a report that analyzes ICC members' utilization of direct access to specialty care.	12/2020

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.

East Cascades WORKS
Connecting Talent To Opportunity

East Cascades Works (EC Works) is a non-profit local workforce board designated by the Governor to oversee the public workforce system, branded as WorkSource, across ten counties east of the Cascades. EC Works is also tasked to be a collaborative, neutral convener, bringing industry, education/training and public sector partners together to ensure that we prepare jobseekers and youth of Hood River, Wasco, Sherman, Gilliam, Wheeler, Crook, Jefferson, Deschutes, Klamath and Lake Counties for family wage earning careers within their home communities.

Part of ensuring the highest quality of WorkSource services is partnering with in-demand industry employers, which in our region are: Healthcare, Manufacturing, Construction, and Technology. Our Industry Engagement work focuses on bringing together industry leaders to solve shared challenges with support from k-20 education, WorkSource, Industry Associations/Chambers, government, and non-profit partners. The key is this is industry led and collaborative.

Our Healthcare Workforce Collaborative, like the others, is convened by EC Works quarterly and chaired and attended by local industry decision makers. The focus is to identify key goals, form sub-committees where necessary, and to continue to work toward the achievement of industry identified goals. EC Works sets the table as the administrative partner and convener and bringing other support partners and resources to the table when needed.

The current work of the Healthcare Workforce Collaborative focuses on the following goals, for which sub-committees have been formed:

- Creating a Central Oregon Behavioral Health Consortium
- Diversifying the Healthcare Industry Pipeline & Creating a Culturally Competent Workforce
- Lowering the Cost of Education to Meet Industry Demand

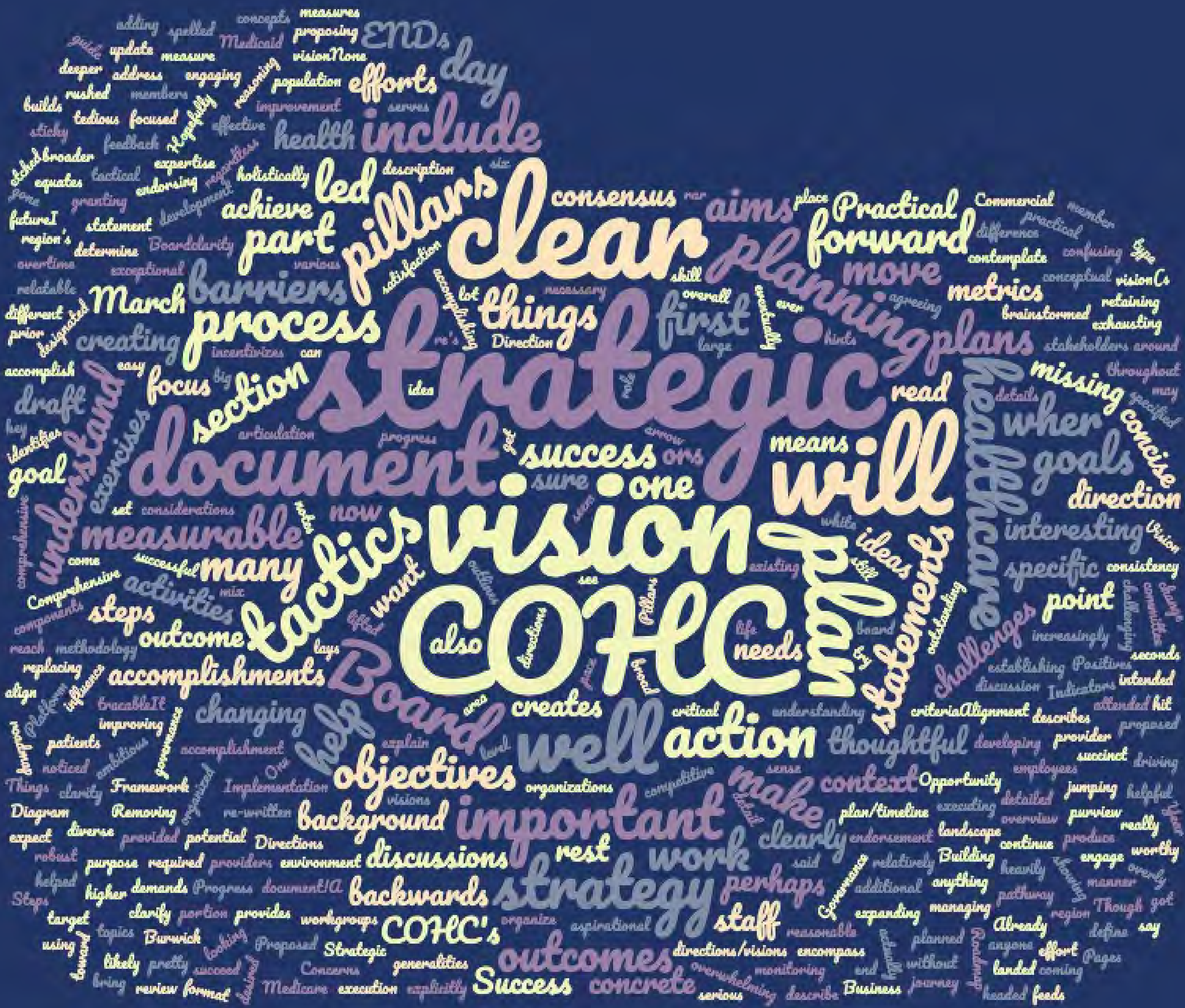
If you are interested in learning more about any of the sub-committees, in joining one of them or the larger collaborative, please reach out to me- my contact info is below.

EC Works would love to hear from you. Email me at jessica@ecworks.org. Call or Text at: 541-904-5084.

1. What are the top workforce challenges you are facing today?
2. Is there support you need to better prepare your workforce? If so, what support do you need and how can we help?
3. Have new workforce priorities emerged that need to be addressed within the next 3-6 months? Can we help you address them?

Jessica Fitzpatrick, Director of Programs from East Cascades Works

Email: jessica@ecworks.org
Phone: 541-904-5084 (Cell)
Website: www.eastcascadesworks.org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missing
read
means
one
sure
now
want
ideas
challenges
activities
exercises
Framework
Implementation
Opportunity
Commercial
Medicare
Medicaid

Central Oregon Health Council

2020-2025 Strategic Plan

Central Oregon Health Council

cohealthcouncil.org

Strategic Directions

- Creating aligned partnerships for innovation between payers, delivery systems, and patients
- Demonstrating effective governance
- Engaging regulators for informed decision-making
- Investing in and developing data infrastructure to support continuous performance improvement
- Identifying and addressing inequities
- Incenting better outcomes

Overview of the Strategic Plan Obstacles

- System and Cultural Inequities
- Uncoordinated Alignment
- The Cost of Change
- Unmet Quadruple Aim
- Continually Evolving Mandates
- We Can't Manage What We Can't Measure
- Complex Systems

Vision

COHC Pillars and 2020-2025 Strategic Plan Visions

Practical Vision: What do we want to see in place with the COHC in the next 5 years?				
Vibrant Healthy Communities	**Sustainable Multi-Sector Integration**	**COHC as the Health Improvement Convener**	**Strong Value & Leadership**	**Exceptional CCO Performance**
Diversity reflected in populations served	Health care coordination community wide	COHC a household name	Data aggregation across all lines of business	100% of provider participation in CCO
High community resilience	Substance use disorder identified and engaged throughout health care	Expand COHC model statewide	Payer alignment	Leading state in QIMs (Quality Incentive Metrics)
Social isolation low & social networks high	School-based medical & dental integration	Broad community awareness	Total cost of care growth under 3.4%	Meet CCO 2.0 criteria
Hospital beds empty, yet St. Charles secure	X% of all providers participating	COHC is laughter, trusting & fun	Increase quality of care	Greater provider satisfaction
Meet three RHA/RHIP objectives @100%	Increased engagement with youth & schools	Collaboration & technology incubator		End OHP patient stigma
High school graduation rate 98%	System of depression/suicide treatment across sectors	Leading Central Oregon health care program convener		
Decrease use of med/surgery & E.D. beds	Increased RHIP measure alignment with partner organizations			
99% of newborns healthy	Strong partnerships with businesses & industry			
Decrease homelessness by increasing affordable housing	K-12 to health careers education & pipeline			
Meet 70% of all RHIP objectives	Secure one new funding stream (in addition to PacificSource)			
X% improvement in County Health Rankings				

Contradictions/Obstacles: What is blocking us from moving toward our Practical Visions?						
System and Cultural Inequities	**Continually Evolving Mandates**	**Uncoordinated Alignment**	**Can't Manage What We Can't Measure**	**The Cost of Change**	**Complex Systems**	**Unmet Quadruple Aim**
Negative past patient experiences	Unstandardized quality measures	Self-interest	Uncoordinated information and focus	Fragmentation of services	Complicated messages	Poorly understood provider satisfaction
Limited services to support patient behavior	Unrealistic expectations from OHA	Misaligned accountability	Unclear Data standards	Motivation and attitude	Narrow knowledge of system	Unmet quality of care
Language Barrier	Unfunded mandates	Misaligned organizational goals impede progress toward collective goals	Siloed information and data	Unmotivated to change	Comprehensive communication plan incomplete	Inadequate patient experience
Inequity	Changing requirements	Conflicting incentives		Narrow trust	Excessive information	High cost of care
Generational trauma				Costly inefficient system currently maintained		Poor Access
Cultural barriers				Inertia in ways to doing business		

STRATEGIC DIRECTIONS: What Moves Us Toward Our 2025 Visions

Deepen Partnership	Innovation	Create Alignment
• Provider Satisfaction Survey • Regular touch points with providers	• Create a "small test of measurable change" plan • Pilot change in small clinic	• Exploit multi-sector ownership of CCO budget

Creating aligned partnerships for innovation between payers, delivery systems and patients

Drive Behavior
• Different payer to align on value based contracts • One interface for all access points for resources (CIE) • Incentive tied to improved partnerships • Increase investment for data hub • Unify HIE/pop health

Incenting better outcomes

Response to Mandate
• Host Don Berwick Summit (triple aim guy) • Be nimble • Prioritization of demands • Insert CAC into policy work • Bring OHA leadership to COHC • Increase advocacy with state

Engaging regulators for informed decision making

Data Collection
• Establish regional "norms" for data set • Establish a Data subcommittee

Investing & developing data infrastructure to support continuous performance improvement

External Communication
• Steward really successful RHIP • Strategic Communications Plan • Round table talks with tech entrepreneurs • Completing the ENDS statement

Demonstrating Effective Governance

Addressing Inequity
• Focus resource investment on needs of rural poor • Increase data capturing to identify disparities • Scale work of Central Oregon (DEI) • Education module on how inequality impacts patient behavior

Identifying & Addressing Inequities

Strategic Direction: Creating Aligned Partnerships for Innovation Between Payers, Delivery Systems, and Patients		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • The CCO promotes alternative payment methodologies (APMs), yet there is still room for improvement. • All sectors are starting to want to work together more. • Our current partners are already motivated to innovate. • Partners struggle to afford business as usual and need financial incentives to push the work forward. • We've done a poor job of engaging patients, and they're not engaged with us. • We have undeveloped relationships in all areas of our region and we need to expand/strengthen connections geographically. • Immense change needs to occur to get fragmented systems to connect. • There is only one payer at the table (PacificSource). • Fragmented payment & benefit system is confusing to patients.	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?*	*What will be different if we really get behind this direction?*
	• Research APM promising practices and models. Discuss pros and cons of each at Operations Council, the Provider Engagement Panel (PEP), Finance Committee, and Cost and Utilization Steering Committee (CUSC).	• 85% of Central Oregon CCO provider contracts will contain APMs.
	• Discuss with Dan Stevens about engaging PacificSource Commercial and Medicare Advantage as additional lines of business for the COHC. • COHC staff conducts grant research.	• We will have at least one additional payer or revenue stream.
	• Launch a small Community Information Exchange (CIE) pilot with three providers.	• 20% of our providers will utilize the CIE as their primary source of connecting patients to outside health and social needs resources.

Strategic Direction: Demonstrating Effective Governance		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • We have a solid foundational relationship with the CCO. • We are activated by results; we are not passive. • The RHIP is integrated (used and implemented) into many of our communities. • The COHC provides regional oversight of the Regional Health Assessment (RHA) data compilation with the help of many partnering organizations. • More Central Oregonians know who we are every day. • There is a perception that we should fund everything, house every community project, and encompass a broader scope. We are often asked to step outside our scope. • Board members have varying levels of engagement and buy-in.	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?* • COHC staff gather and share tools/strategies to explore opportunities for workgroups to implement/fund multi-sector projects. • Finalize the ENDS statement. • Develop simple and concise multi-level external communications plan for board member and partner use.	*What will be different if we really get behind this direction?* • 40% of all 2020-2023 RHIP funded projects will reflect multi-sector partnerships with two or more different sectors (excluding mini-grants). • 100% of Board members (with the exception of community representatives) will discuss and at least 50% will incorporate aspects of the COHC's strategic plan into their organization's next strategic plan. • 100% of Board members (with the exception of community representatives) will discuss and at least 50% will incorporate one or more priorities of the current RHIP into their organization's next strategic plan.

Strategic Direction: Engaging Regulators for Informed Decision-Making		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • The Oregon Health Authority (OHA) somewhat knows who we are. • We are connected to OHA through the Older Adult Behavioral Health Initiative (OABHI) housed within the COHC. • We are a subcontractor of the CCO, and this complicates communication directly with the OHA. • The Community Advisory Council (CAC) is not entirely clear on their current scope and role in regard to policy advocacy. • The COHC is not allowed to lobby, but we can advocate and educate. • The COHC has very little input into OHA's regulations placed on the CCO.	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?* • Map OHA's organizational structure and origination of CCO mandates. • Schedule introductions with three OHA decision-makers. • The COHC Board, committees & workgroups will receive advocacy training and education.	*What will be different if we really get behind this direction?* • Develop three new responsive relationships with OHA decision-makers who provide guidance on CCO regulations. • The CAC will advocate for and educate regulators on three pieces of health-related policy. • The COHC Board, committees & workgroups will advocate for and educate regulators on 12 pieces of health-related policy.

Strategic Direction: Investing In and Developing Data Infrastructures to Support Continuous Performance Improvement		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • We are currently in the early stages of developing our community health data website. • Quality Incentive Measure (QIM) data sharing already takes place among clinics and organizations. • We draw data from various sources. • The COHC is not a source of primary data. • We don't have sources of comparable data to pull from in a timely manner, with the exception of QIMs. • There is an appetite for data consideration and use. • Community has an expectation that some data already exists when it does not. • Medicaid claims expenses are trending upward, and we currently cannot explain why. • Data streams & reporting requirements are separate (i.e., RHIP, QIM, CCO performance, public health, hospital).	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?* • Establish data subcommittee with clear objectives (Cost and Utilization Steering Committee (CUSC). • The data subcommittee will identify a subset of datapoints (minimum of 10) to develop the pilot. • Obtain MOUs from the three pilot participants/data contributors.	*What will be different if we really get behind this direction?* • At least three Board member organizations will be financially invested in the development of a data infrastructure pilot. • We will observe an incremental (2%) decrease in the cost of care due to the data infrastructure pilot. • One data infrastructure pilot will be launched.

Strategic Direction: Identifying and Addressing Inequities		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • We established the Central Oregon Diversity, Equity, and Inclusion (CODEI) group. • We have various levels of understanding of Diversity, Equity, and Inclusion (DEI) and their impacts on health in our region. • DEI has not been a main priority. • We expect workgroups will support these efforts. • The COHC's role is undefined in addressing health inequity in communities. • CCO 2.0 has DEI mandates. • CODEI is establishing a connection to the RHIP workgroups and the CCO's work. • There is no tribal representation on the COHC Board, and it is currently not required by legislation. • The Board's bylaws do not currently reflect our DEI needs.	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?* • The Governance Committee will review Board's bylaws to ensure equity goals are met. • Develop and begin collecting three COHC organizational DEI metrics. • Develop and implement tools to support regular consideration and use of an equity lens in all COHC committee and workgroups (to better respond to needs of rural and marginalized communities).	*What will be different if we really get behind this direction?* • The COHC Board will encourage membership from the Confederated Tribes of Warm Springs Council. • When one of the four "Director-at-Large" seats becomes vacant, the COHC Board will encourage membership representing diverse communities experiencing disparities. • 40% of RHIP funds will go to projects primarily affecting rural and marginalized communities. • The COHC Board, staff, committees, and workgroups will promote and ensure equity in their roles.

Strategic Direction: Incenting Better Outcomes		
Current Reality	**Proposed First Year Accomplishments**	**Success Indicators In 2-3 Years**
What are characteristics (positive and negative) of the current situation around this strategic direction? • There are no other payers at the table. • Community Information Exchange (CIE) is in process. • Incenting partnership has been minimally explored. • Health Information Exchange (HIE) is in its early stages. • RHIP funding is tied specifically to RHIP metrics. • The abundance of incentive metrics creates competing priorities.	*What do we need to accomplish in the next 12 months, in terms of programs, projects, or events to move us from reality to success?*	*What will be different if we really get behind this direction?*
	• Design a disincentive for poor QIM performance.	• 100% payout of QIMs each year.
	• Educate RHIP workgroups on the self-sufficiency matrix. • Launch one pilot to test run incentivizing through a self-sufficiency matrix.	• Twenty local projects use a self-sufficiency matrix to measure outcomes. • We've developed a proven method for incentivizing success through self-sufficiency matrices.
	• Develop standards of demonstrated cost-savings that qualify recommending a project for inclusion in contracting/the global budget.	• A minimum of three successful pilot projects proving cost savings are built into contracts within the global budget.

Year One Accomplishments by Quarter				
Strategic Directions	***Quarter 2 – 2020*** **April – June 2020**	***Quarter 3 – 2020*** **July – September 2020**	***Quarter 4 – 2020*** **October – December 2020**	***Quarter 1 – 2021*** **January – March 2021**
Creating Aligned Partnerships for Innovation Between Payers, Delivery Systems, and Patients		• Launch a small Community Information Exchange (CIE) pilot with three providers. • COHC staff conducts grant research.	• Research APM promising practices and models. Discuss pros and cons of each at Operations Council, the Provider Engagement Panel (PEP), Finance Committee, and Cost and Utilization Steering Committee (CUSC). • Discuss with Dan Stevens about engaging PacificSource Commercial and Medicare Advantage as additional lines of business for the COHC.	
Demonstrating Effective Governance	• COHC staff gather and share tools/strategies to explore opportunities for workgroups to implement/fund multi-sector projects.	• Finalize the ENDS statement.	• Develop simple and concise multi-level external communications plan for board member and partner use.	
Engaging Regulators For Informed Decision-Making		• Map OHA's organizational structure and origination of CCO mandates.	• Schedule introductions with three OHA decision-makers.	• The COHC Board, committees & workgroups will receive advocacy training and education.

Investing In and Developing Data Infrastructure to Support Continuous Performance Improvement	• Establish data subcommittee with clear objectives (Cost and Utilization Steering Committee (CUSC).	• The data subcommittee will identify a subset of datapoints (minimum of 10) to develop the pilot.	• Obtain MOUs from the three pilot participants/data contributors.	
Identifying and Addressing Inequities		• Develop and implement tools to support regular consideration and use of an equity lens in all COHC committee and workgroups (to better respond to needs of rural and marginalized communities).	• The Governance Committee will review Board's bylaws to ensure equity goals are met.	• Develop and begin collecting three COHC organizational DEI metrics.
Incenting Better Outcomes		• Educate RHIP workgroups on the self-sufficiency matrix.	• Design a disincentive for poor QIM performance. • Develop standards of demonstrated cost-savings that qualify recommending a project for inclusion in contracting/the global budget.	• Launch one pilot to test run incentivizing through a self-sufficiency matrix.

90-Day Implementation Steps for Quarter 2, 2020 (April-June 2020)				
Strategic Direction: Demonstrating Effective Governance	**Accomplishment**: Gather and share tools/strategies to explore opportunities for workgroups to implement/fund multi-sector projects.			
	Start date: 2.1.2020		End date: 6.30.2020	
Implementation Steps (How)	**Who**	**By When**	**Where**	**Costs/other resources**
Share "Circles of Involvement" Technology of Participation (ToP) strategy with workgroups.	MaCayla	2.29.2020	RHIP Workgroups	COHC staff FTE
Flesh out grant rating criteria to include multi-sector project rating	MaCayla, Renee, Gwen, and Rebeckah	4.30.2020	RHIP Workgroups	COHC staff FTE
Previously funded projects/initiatives portfolio development	Kelsey and Rebeckah	5.31.2020	RHIP Workgroups	COHC staff FTE
Share and discuss multi-sector strategies from Collective Impact model.	MaCayla, Renee, and Gwen	6.30.2020	RHIP Workgroups	COHC staff FTE

Implementation Team:	Collaborators/Partners:	Next meeting check in, or coordination dates:	Evaluation measures:	Budget:
Kelsey Gwen Renee MaCayla	Workgroup partners Rebeckah	Weekly	Confirm completion by workgroup agenda items	COHC Staff FTE

90-Day Implementation Steps for Quarter 2, 2020 (April-June 2020)			
Strategic Direction: Investing In and Developing Data Infrastructure to Support Continuous Performance Improvement	**Accomplishment**: Establish data subcommittee with clear objectives (Cost and Utilization Steering Committee (CUSC).		
	Start date: 2.1.2020		End date: 4.30.2020
Implementation Steps (How)	**Who**	**By When**	**Costs/other resources**
Board directs Finance Committee to create a task force: Cost and Utilization Steering Committee (CUSC)	Donna	2.29.2020	COHC staff FTE
Create membership/scope and charge	Donna, Kelsey, and Finance Committee	3.31.2020	COHC staff FTE & Finance Committee time
Hold first CUSC meeting	Donna	3.31.2020	COHC staff FTE & CUSC participants time
Request data from PacificSource to share	Donna	3.31.2020	COHC and PacificSource staff FTE
Hold analysts-only meeting to investigate the Prometheus tool	Donna	3.31.2020	COHC staff FTE & analysts' FTE
Schedule two more meetings of analysts-only	Kelsey	4.3.2020	COHC staff FTE
Schedule CUSC monthly cadence	Kelsey	4.15.2020	COHC staff FTE

Implementation Team:	Collaborators/Partners:	Next meeting check in, or coordination dates:	Evaluation measures:	Budget:
Donna Kelsey Finance Committee	Rick Treleaven Divya Sharma CUSC analysts CUSC members	Weekly, then monthly	Approved scope & charge, organizational structure, and regularly occurring meetings	COHC staff and partners FTE

2020 CCO Objectives and Performance Metrics: Q1 2020 (January, February, March)

Quality & Member Experience

1. Quality Incentive Measures (QIMs)
   Metric: Achieve at least 100% withhold return on QIM measures (earned in 2020, paid in 2021)
   Performance: This is a bit hard to assess, as we are waiting for an update from Metrics and Scoring on which measures will go forward and how. Most clinics have continued their monthly quality meetings with PacificSource to examine performance and develop strategies to target metrics when clinics begin to open for more preventive services.

   With respect to the 2019 quality measures, the dashboard we just received indicated a 100% performance level. Some of the OHA data seem inconsistent with our information, and we are still in the validation phase, but this is some preliminary good news.
2. OHA Performance Improvement Plans (PIPs)
   Metric: All projects meet OHA deliverables
   Performance: We received feedback on the opioid prescribing Performance Improvement Plan (PIP). The CCO met requirements and passed at a 100% level.
3. OHA Transformation and Quality Strategy (TQS) Plan
   Metric: All 2020 projects meet OHA deliverables
   Performance: We timely submitted the TQS in March 2020. We are waiting for feedback from the OHA.

Financial Stability

1. Maintain a stable CCO financial position and achieve cost of care targets
   Metric: Emergency department utilization for individuals experiencing mental illness (2020 target TBD, 2019 target: <98.4)
   Performance: 94.3
   Metric: ED utilization rate/1000 (2020 target TBD, 2019 target: <43.6)
   Performance: 44.1 at the end of 2019 with runout through March 2020
   Metric: 30 day all-cause readmission rate (2020 target TBD, 2019 target: <11.9%)
   Performance: 13.9% at the end of 2019 with runout through March 2020
   Metric: Meeting or beating the CCO budget (reporting quarterly)
   Performance: Budgeted membership for March was 48,891. Actual membership was 52,387. For the three months ending March 31, 2020, we budgeted 2.37% for net income. Actual net income as a percentage of premiums was -3.16%.

CCO 2.0 Requirements

1. Develop and implement new/expanded VBPs (value-based payments) in behavioral health, hospital, and maternity services
   Metric: In 2020, evaluate and agree to implement VBPs in behavioral health/hospital (Sage View) and maternity to implement by January 1, 2021.
   Performance: VBP specific to Sage View is part of the 2020 contract. First meeting of providers held in March to discuss workflows around meeting all behavioral health hospital metrics.
2. CCO VBP roadmap and existing arrangements
   Metric: Monitor regional progress towards 70% of payments in a VBP arrangement (70% is the benchmark for 2024)
   Performance: The OHA has delayed reporting but has not waived this requirement. We remain on track with the targets submitted in the CCO 2.0 RFA submission. PCS will continue to work with providers to meet the annual percentage goal of value-based

CCO Operations

1. CCO call center performance
   Metric: 80% of calls answered within 30 seconds
   Performance: For weeks 1-12 in 2020, the average was 31.4%. For weeks 13-17, service levels were above 80%, and, in some cases, over 90%. For April, the service level was over 87% on average and the abandonment rate was 1.24%. The average wait time was 21 seconds.
2. CCO timely and accurate claims payment
   Metric: 99% of claims paid within 30 days of receipt
   Performance: For 7 weeks in 2020, we met this service level. During the entire quarter, 14.8% of claims were not paid within 30 days of receipt.
3. Performance against OHA compliance standards
   Metric: Pass External Quality Review audit with OHA
   Performance: The HSAG review has been adjusted this year due to COVID-19. At this time, we know that our documentation submission is scheduled for August 14, 2020; on-site reviews are scheduled mid-

contracting with each negotiation cycle over the 5-year period. Updated reporting schedule pending OHA clarification. 3. Traditional Health Worker (THW) planning **Metric**: In 2020, develop and implement various payment methodologies to support THW workforce and utilization ***Performance:*** The OHA delayed the due date of the THW Payment Grid from April 15 until November 15, 2020. Payment methodologies for all THW types have been developed and will be finalized by September. We are currently awaiting additional information from the State THW Commission, which expects to release Community Health Worker billing codes in June, and guidance from the OHA on community-based organizations and THWs working in organizations that cannot submit claims. 4. Standing up 2.0 funding streams **Metric**: Ensure all 2.0 funding streams (Quality Pool, Health-Related Services-Community Benefit Initiative, Social Determinants of Health and Equity, and Supporting Health for All Through Reinvestment (SHARE)) meet OHA requirements and have timely documented processes in place ***Performance:*** In 2020, (1) distribute and track all 2020 CBI funds, as decided by the CAC, and (2) agree to allocations for 2021 SDOH-E funding from 2020 Quality Pool and SHARE (from shared savings earned in 2020). The Central Oregon Health Council (COHC) will be allocating these dollars through a mini-grants process and will be training the CAC to use a grant review process to determine who receives funding.	September through October 1, 2020. Internally, we are developing our gap assessment and will send out initial communications to internal departments by May 14.

Central Oregon Health Council
Executive Director's Update
May 14, 2020

- Facilitate PEP meeting
- Facilitate Finance meeting
- Multiple stakeholder/community meetings
- Steering committee for TRACES work (United Way)
- EL Hub as ex-officio member
- El Hub Investment Steering Committee
- Central Oregon Suicide Prevention Alliance Leadership
- COHIE Board Member – HIE
- Fiscal agent for Social Services Steering platform
- System of Care Executive Team member
- Grant software management
- Managing PDO, OHA and OCR grant funds
- Managing OABHI contract
- CCO 2.0 alignment and support and training
- Board Governance Committee support
- Project plan for Board Governance work (ENDS)
- Childcare Accelerator steering committee
- Strategic plan work with staff/Board for 2020-2025 – Board Retreat
- Standing up Budget Task Force/scrubbing Committee Structure
- Board Retreat
- Launch Central Oregon Resource Directory (CORD) in partnership with Joint Incident Command for Central Oregon
- Close office and provide for minimal disruption to staff, committees, workgroups and community
- Team development of Mini-grant process (COVID-19 and RHIP)
- Review, vet, approve and fund Mini-grants
- Translate CORD into Spanish

Coming up:

- Robert Wood Johnson Foundation Aligning Systems for Health informant interview –

COHC Community Advisory Council
Advantage Dental, Training Room
Redmond, Oregon
February 13, 2020

Present:
Linda McCoy, Chair, Consumer Representative
Larry Kogosvek, Vice Chair, Consumer Representative
Jolene Greene, Consumer Representative
Linda Johnson, Community Representative
Elaine Knobbs-Seasholtz, Mosaic Medical
Tom Kuhn, Deschutes County Health Services (Ex-Officio) (call-in)
Brad Porterfield, Consumer Representative
Vicky Ryan, Crook County Health Department (Ex-Officio)
Elizabeth Schmitt, Consumer Representative
Ken Wilhelm, United Way of Deschutes County
Cris Woodard, Consumer Representative

Absent:
Michael Baker, Jefferson County Health (Ex-Officio)

Others Present:
MaCayla Arsenault, Central Oregon Health Council
Suzanne Browning, Kemple Memorial Clinic (call-in)
Gwen Jones, Central Oregon Health Council
Donna Mills, Central Oregon Health Council
Tanya Nason, PacificSource
Leslie Neugebauer, PacificSource
Kelsey Seymour, Central Oregon Health Council
Elena Sierra, NeighborImpact
Jessica Strecker, NeighborImpact
Maria Waters, Oregon Health Authority
Renee Wirth, Central Oregon Health Council
Dustin Zimmerman, Oregon Health Authority

Introductions

- Introductions were made and Linda McCoy welcomed all attendees.

Public Comment

- Linda McCoy welcomed public comment. Suzanne Browning announced that Kemple Clinic is closing and will be folded into Mosaic Medical. Elaine-Knobbs Seasholtz recognized the efforts of Dr. Kemple, noting Mosaic will establish the Kemple Memorial Children's Dental Fund.

Community Lens: Assistor Sharing

- Elena Sierra introduced herself as an OHP enrollment assistor with NeighborImpact, and shared that she works onsite at both Madras High School and Redmond Early Learning Center. She shared they have struggled to build relationships with the Madras community and the high school, and that not enough people know their services are available.
- Elena shared that all school districts (except Redmond) do not ask students if they have health insurance coverage, which makes it harder to identify which students need help. She added that lapsing coverage is an area of concern also for families with young children.
- Jessica Strecker shared her focus is on the Head Start population, including pregnant women with children up to age 5. She shared that parents struggle to access dental care both for themselves and their children, with appointments scheduled unreasonably far out. She noted families have difficulty connecting to their primary care providers, accessing mental health care, and obtaining medications.
- Donna Mills asked if the 100% project launched by OHA regarding enrollment for uninsured children has an end date. Maria Waters shared the program's funding does not have an end date set. She noted that an estimated 400 to 500 children in Central Oregon remain uninsured.
- Jessica shared that bilingual services are not often available, and even if they are, translators do not answer the phone.
- Elaine asked if the fear of public charge is influencing parents to not enroll their children. Elena stated that the fear of public charge is high and families don't trust the assistors to have all the facts; they want to hear it from an immigration lawyer. Jolene Greene suggested an FAQ flyer. Jessica noted that a flyer exists, and MaCayla agreed to send it out to the group.
    - ACTION: MaCayla will send the Public Charge FAQ flyer to the group.
- MaCayla Arsenault asked Council members follow-up questions about the Assistors' stories.
    - What stood out?
        - Linda McCoy shared that the medical insurance used to be on Madras school forms and they used to offer insurance assistance to students.
        - Elaine noted how important relationships and presence are.
    - What stories were brought up for you?

        - Linda Johnson shared the difficulty of accessing children who need OHP through schools, and what COHC's role is in assisting there.
        - Larry Kogovsek shared about immigration strife.
    - What does this information mean for the community?
        - Linda McCoy noted there is increased fear regarding public charge.
        - Linda Johnson shared that some solutions may not be high tech or complex, they can be as simple as strong relationships.
        - Tanya Nason noted that not being able to reach a bilingual representative is a problem; Elaine noted there is no disincentive for clinics providing sub-par bilingual access.
    - What does it mean for the CAC?
        - Linda McCoy suggested discussing the health insurance question on school enrollment forms with Paul Andrews from the High Desert Education Service District.
        - Brad Porterfield shared the Latino Community Association can keep pushing on public charge.
        - Linda Johnson suggested sharing the list of Assistor comments with the COHC Board.
        - Elaine suggested the CAC could focus their Community Benefit Initiative money on issues like immigration barriers.

Transformation Quality Strategy

- Leslie shared the fourteen components of the TQS. She noted all components are addressed within 7 proposed projects that also align with the RHIP and CCO 2.0.

Community Benefit Initiative – OHSU Project ECHO

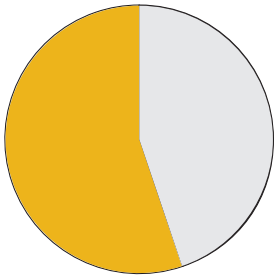
- Leslie shared that the CAC will receive approximately $250,000 each year to dispense for Social Determinants of Health & Health Equity. She explained that in the past, PacificSource managed these dollars, and used them to pay for the ECHO project. Donna Mills noted that the Provider Engagement Panel fully endorses the ECHO project. She explained that there is no cost to providers, the program discusses real cases, and reduces specialty referrals by expanding provider capacity for treating patients.
- MaCayla noted that normally requests for funds would not come to the CAC this way, and this is a special case because of the transition into CCO 2.0.
    - Motion: Linda Johnson motioned to approve funding the ECHO project; Ken Wilhelm seconded. Brad requested outcomes for the ECHO project at a future meeting. The motion passed.
    - ACTION: Leslie will bring outcomes from the ECHO project back to the CAC.
- Linda McCoy asked the COHC staff to draft a letter on behalf of the CAC explaining how long wait times and CCO changes adversely affect care.
    - ACTION: COHC Staff will draft a letter to OHA on behalf of the CAC.

Structured Problem Solving Continuation

- MaCayla and Gwen Jones continued leading the CAC through their structured problem solving session.

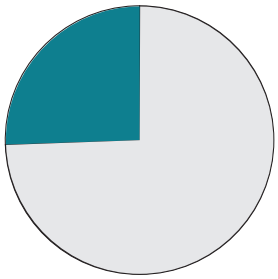
Central Oregon Health Council
COVID-19
Mini-Grant Report

Non-RHIP



$82,640 Remaining
$67,360 Spent

RHIP



$38,130 Remaining
$111,870 Spent

This report gives an overview of the status of all COVID-19 mini-grants funded by the Central Oregon Health Council (COHC).

There are two funding streams available for COVID-19 mini-grants. One is from the **RHIP Workgroups**, who elected to pool their money. Each workgroup contributed $25,000, for a total of $150,000. Grant applications for this funding stream directly impact a RHIP metric. See pages two and beyond for information on which metrics have been impacted through COVID-19 mini-grants.

The second funding stream is provided from **the COHC reserves** in a matching amount of $150,000.This funding pool is drawn from when a COVID-19 mini-grant is submitted due to an emergent need, but does not align with a RHIP metric. See a complete list of these mini-grants on the bottom half of page one.

Non-RHIP COVID-19 Mini-Grants

MARCH

Creach Consulting, LLC COVID-19 Virtual Community Supports
Jefferson County Public Health Department Stay Home, Save Lives Outreach Campaign
Jefferson County Public Health Department Prevent COVID-19 for At-Risk Populations
Mosaic Medical COVID-19 Care Kits for the Homeless

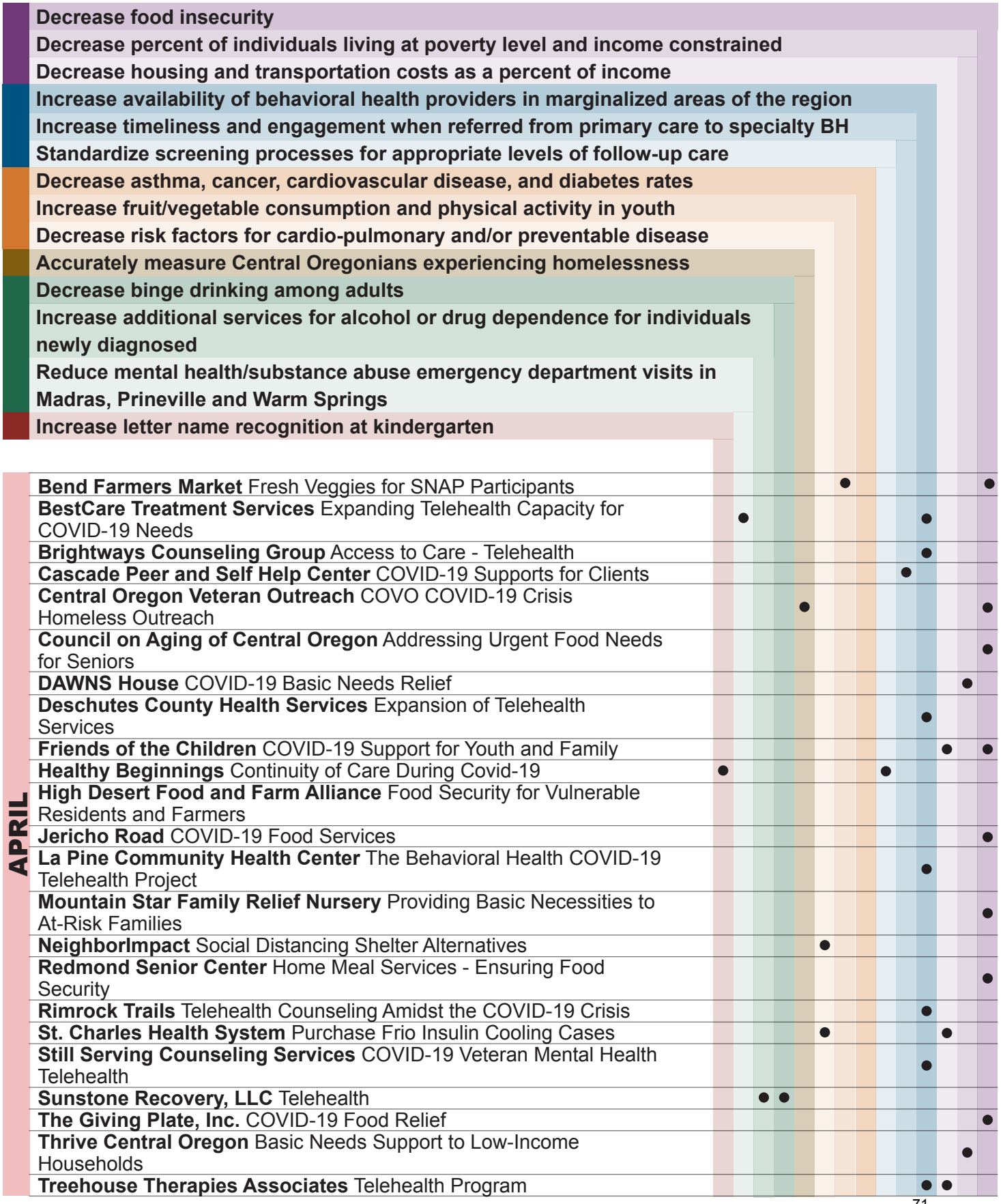
APRIL

Central Oregon Pediatric Associates PPE Sterilization
Crook County Health Department COVID-19 Outreach Campaign
Family Access Network FAN COVID-19 Response
NeighborImpact Homeless Services
REACH COVID-19 Services for Homeless
Ronald McDonald House Charities COVID-19 Virtual Family Supports
Rugged Thread Outerwear Repair Inc. Manufacturing Surgical Masks
Sparrow Clubs U.S.A. Virtual Sparrow Clubs for 2020-21 School Year
The Latino Community Association COVID-19 Emergency Funds for Families

MAY

REACH Solar Chargers for Homeless

RHIP COVID-19 Mini-Grants



RHIP COVID-19 Mini-Grants (cont'd)