Columbia Pacific CCO™

Part of the CareOregon Family

OHA Transformation and Quality Strategy (TQS)
2023

CCO: Columbia Pacific CCO

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Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 78: PCPCH Supports

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

If continued, insert unique project ID from OHA: 78

B. Components addressed

a. Component 1: PCPCH: Tier advancement
b. Component 2 (if applicable): PCPCH: Member enrollment
c. Component 3 (if applicable): CLAS standards
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinant of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Assessment of the Patient Centered Primary Care Home (PCPCH) status of our network is tracked by Oregon Health Authority's (OHA) PCPCH Recognition Information for Oregon Payers excel document. Columbia Pacific CCO ingests these status updates into our provider data information platform quarterly and annually translates this into a map across our counties: Columbia, Clatsop, and Tillamook. We use this data to do proactive outreach to clinics in areas with no or few PCPCH recognized clinics represented by the orange circles. We incentivize tier recognition by requiring clinics to be PCPCH tier 3 to participate in our Primary Care Payment Model (PCPM) and requiring PCPCH recognition to get quality bonus payout for CCO metrics. Clinics that are in other value-based payment arrangements aside from our PCPM are incentivized by having their payment levels adjusted according to PCPCH tier status. In 2021, 93% of Columbia Pacific CCO members were assigned to PCPCH recognized primary care clinics.

In 2022 we identified specific clinics that were not recognized as PCPCH and had members assigned. We intended to reach out to those clinics -- Steven Vander Waal and Columbia Pacific Medical Services -- but were notified that Steven Vander Waal is retiring and the 166 members assigned to that clinic will be reassigned based on our reassignment formula below. We also decided Columbia Pacific Medical Services' low CPCCO member enrollment of 121 members is not an incentive for that clinic to pursue PCPCH recognition. Below is our map to show PCPCH recognition and tier level in the region (Figure 1).

In addition to recognition opportunities, we always provide technical assistance to the clinics when they need or request it for attestation but the clinics who did attest in 2022 did not need technical assistance. These are the clinics that attested in 2022.

- Columbia Health Services: Sacagawea Clinic on 1/12/2022
- Columbia Health Services: Rainier Clinic on 2/1/2022

- Providence: Seaside, Cannon Beach, and Warrenton Clinics on 12/7/22
- Coastal Family Health Center: Astoria on 12/16/22

While we did not provide specific technical assistance for PCPCH last year, we did discuss opportunities to improve quality of care through access and outreach interventions to members that were not consistently seen at the clinic to optimize member enrollment.

Figure 1: Map to show PCPCH recognition and Tier Level

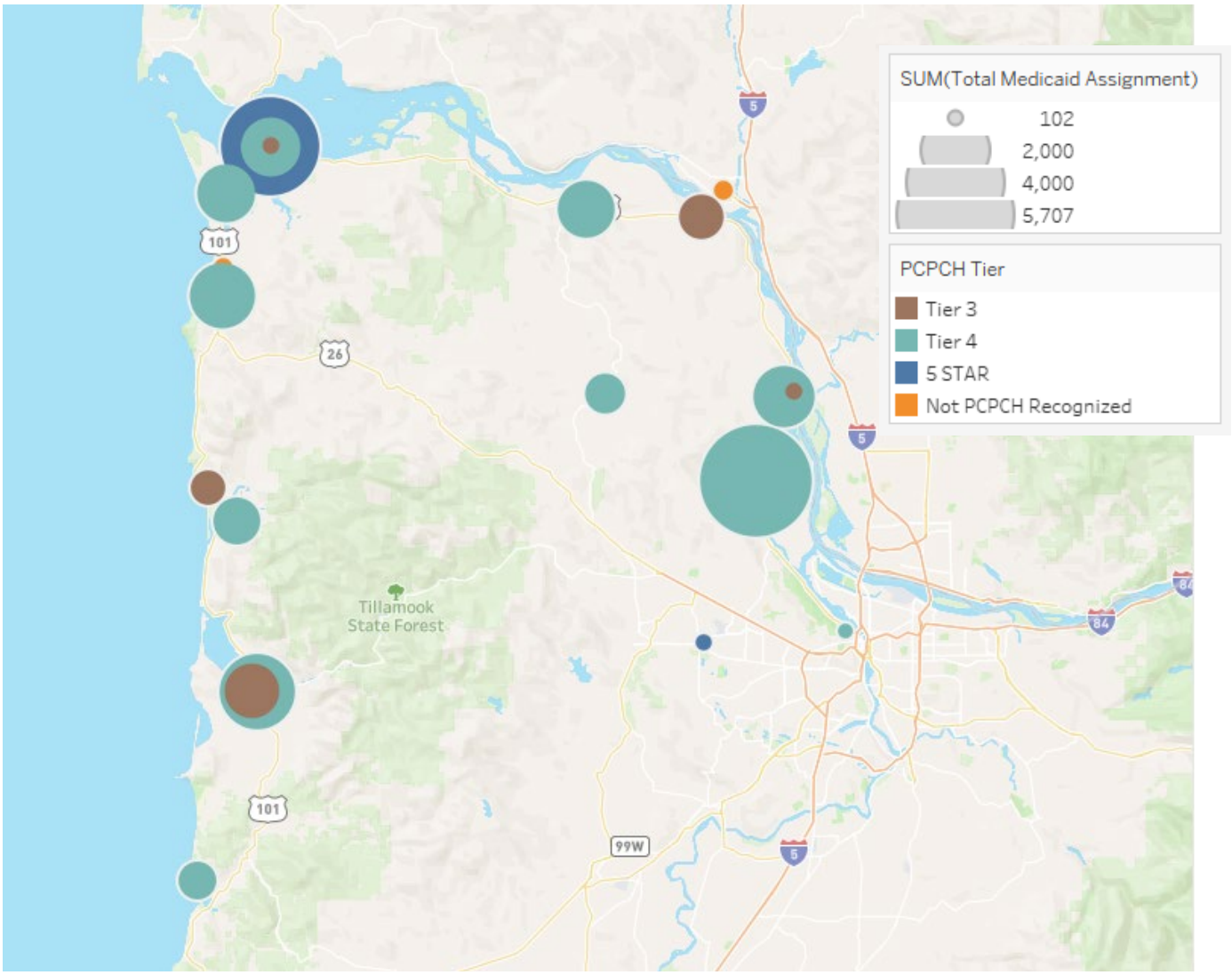

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Table 1: Number of CPCCO Members, Clinics by name and Tier Levels

PCPCH Tier	Pcpname	# of Members Assigned
Not PCPCH Recognized	VANDER WAAL, STEVEN C	166
	PEACEHEALTH FAMILY PRACTICE LAKEFRONT	164
	COLUMBIA PACIFIC MEDICAL SERVICES	121
Tier 3	ADVENTIST HEALTH TILLAMOOK MED GRP WOMENS & FAMILY HEALTH	1377
	RAINIER HEALTH CENTER	913
	ADVENTIST HEALTH TILLAMOOK MEDICAL GROUP MANZANITA	546
	THE MIDDLE WAY HEALTH CARE	226
	SACAGAWEA HEALTH CENTER	139
	WIMAHL FAMILY CLINIC INC	132
Tier 4	OHSU FAMILY HEALTH CENTER AT SCAPPOOSE	5707
	TILLAMOOK COUNTY COMMUNITY HEALTH CENTERS	2600
	PROVIDENCE SEASIDE CLINIC	1957
	ADVENTIST TILLAMOOK MEDICAL PLAZA	1738
	LEGACY CLINIC ST HELENS INTERNAL MEDICINE	1721
	CMH PEDIATRIC CLINIC	1609
	CMH PRIMARY CARE CLINIC	1546
	CMH ASTORIA PRIMARY CARE CLINIC	1506
	COMMUNITY HEALTH CENTER OF CLATSKANIE	1493
	LEGACY CLINIC ST HELENS PEDIATRICS	1247
	RINEHART CLINIC	1011
	CMH MEDICAL GROUP & URGENT CARE - SEASIDE	913
	ADVENTIST HEALTH TILLAMOOK MEDICAL GROUP VERNONIA	733
	ADVENTIST HEALTH BAYSHORE MEDICAL PACIFIC CITY	656
	FLEWELLING, KATHLEEN R	246
	PEDIATRIC ASSOCIATES OF THE NW - PORTLAND	102
5 STAR	COASTAL FAMILY HEALTH CENTER	4423
	HILLSBORO PEDIATRIC CLINIC - MAIN ST	111

The view is broken down by PCPCH Tier, Pcpname and # of Members Assigned. The data is filtered on Total Medicaid Assignment, which includes values greater than or equal to 100.

Please see Section E for PCPCH data disaggregated by race/ethnicity and language.

Table 2: Membership assigned to PCPCH clinics.

Total CPCCO Membership assigned							
Members in non-PCPCH clinics	Members in Tier 1	Members in Tier 2	Members in Tier 3	Members in Tier 4	Members in Tier 5	**Total CPCCO Physical Health Membership**	**Total PCPCH percentage member assignment**
918	0	0	3,447	26,138	4,894	**35,397**	**97.4%**

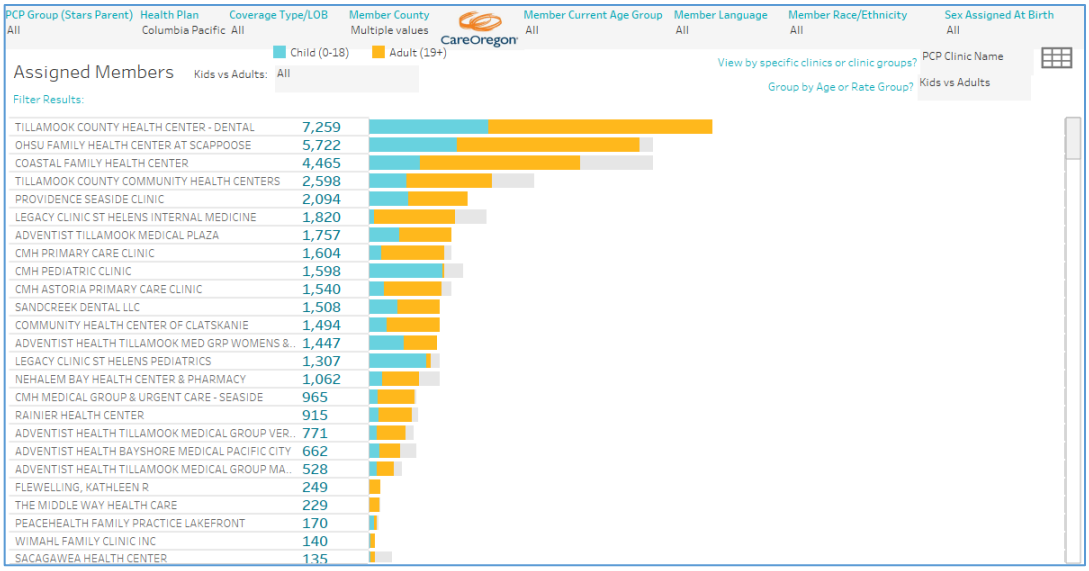
D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

As of 12/31/22, 97.4% of Columbia Pacific CCO members were assigned to PCPCH recognized primary care clinics. This is an increase from last year's 93%. You can see this broken down in the table above (Table 2) by Tier level and CPCCO membership. At the end of last year, we had a weighted percentage of 78.6%. Due to the increase in members being seen at PCPCH recognized clinics this is an improvement.

In 2022, we did meet our target to maintain CPCCO Quality Improvement Workgroup (QIW) as a specific venue to coach, guide and support clinics to re-attest or newly recognize their PCPCH status. By the end of 2022, 5 clinics re-attested and were successful. We have 14 clinics who need to attest in 2023 and will reach out **3 months prior** to the due date in an email to: 1) remind them of the upcoming date and 2) offer assistance for attestation. Those 14 clinics are:

- Columbia Memorial Hospital - (Warrenton) Primary Care
- Columbia Memorial Hospital - Pediatric Clinic
- Columbia Memorial Hospital - Astoria Primary Care
- Columbia Memorial Hospital - Seaside & Urgent Care
- Adventist Health - Pacific City
- Adventist Health - Vernonia
- Adventist Health - Tillamook Family Health
- Adventist Health - Tillamook Plaza
- Adventist Health - Manzanita
- Middle Way Health Care
- Oregon Health Science University - Scappoose
- Rinehart Clinic
- Tillamook County Community Health Center
- Legacy - St Helens

Below is a snapshot of current enrollment data. While not disaggregated here, we have the ability to filter by race/ethnicity, language and sex assigned at birth as illustrated on the dashboard.



This coming year we will use QIW to support things like sample policy and procedures from other clinics, navigation support of the application, or support for their EMR systems to pull data. QIW is comprised of practice administration, quality improvement staff and/or clinical providers to also inform re-attestation deadlines and resources to complete state recognition status. Communication will continue to be sent to all clinics in our region to help especially if new standards arise.

Last year's Activity 1 and Activity 2 were both met. Activity 1 being QIW as a main vehicle for clinic improvement and tier advancement and Activity 2 being outreach and providing technical assistance to clinics that are not PCPCH recognized. The target/benchmark to increase QIW engagement was met with 9 organizations and 21 primary care clinics being present throughout 2022. This was listed as a long-term measure and will remain so as we acknowledge if clinics are continuing to engage or are not in 2023 and will discuss approaching those to increase engagement. Activity 2 was met by outreaching to Steve Vander Waal and Columbia Pacific Medical Services even though they will not be pursuing recognition.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In 2023, our interventions for the quality and transformative components are explained below.

PCPCH Tier Advancement component

We have quality meetings every other month with the clinics below and will bring this to those individual conversations for tier advancement. The clinics we will be focusing on are:

<u>Tillamook County:</u>

- **Adventist Health Tillamook Medical Group Women's and Family Health** due to attest in 2023 and **Adventist Health Tillamook Medical Group Manzanita** due to attest in 2023
    - In our individual technical assistance meetings, we will provide support to help these clinics move from a Tier 3 to a Tier 4.
- **Tillamook County Community Health Center** due to attest in 2023

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- We will provide assistance to their north county clinic to help move from a Tier 3 to a Tier 4. We are also partnering with Tillamook County Health Department as they join ORPRN's TA cohort around SDoH screening. Tillamook County Health Department has one clinic recognized as Tier 4. Most of the program is 1:1 TA (up to 12 hours per clinic) where current processes are analyzed, gaps are identified, and PDSA's are implemented to achieve goals in better social health screening. This will help Tillamook County Health Department strengthen their standing in section 3.D Comprehensive Health Assessment and Intervention and 3.D.1 Routine Assessment to Identify Health-Related Social Needs. The learnings and growth from this opportunity will be shared and spread throughout the network in other learning collaboratives, which will strengthen the entire network's work as it relates to social health screening.

Columbia County:

- **Rainier Health Center** due to attest in 2024 and **Sacagawea Health Center** due to attest in 2024 (Columbia Health Services organization)
    - We will be working with Columbia Health Services to move their clinics from a Tier 3 to a Tier 4. Additionally, we are discussing possible future Federally Qualified Health Center status with Rainier and Sacagawea clinics as well as funding for integrated behavioral health services.

PCPCH Member Enrollment and CLAS Standards component:

Although we acknowledge it is important to provide membership support by ensuring members are being served with the highest quality of care, we have a small number of clinics who are not interested in recognition but do have patients that could use support for their interpretation needs. Therefore, we are pursuing other opportunities using REALD to analyze further transformative care for specific member populations in the non-PCPCH clinics to meet the PCPCH Member Enrollment component and the CLAS standard #5. Since PCPCH requires clinics to document patients' preferred language (4.C.0) and encourages clinics to stratify metric performance by REALD we think members who communicate in a language other than English might be better served by a PCPCH. This also supports member services in relation to our other TQS project: Meaningful Language Access; in that project we are focusing on the network and how they respond and care for those that need interpretation in their clinics.

In 2023, we are identifying the need for all members who are seeking care in non-PCPCH recognized clinics that have language interpretation needs. As we analyze, we will determine if their interpretation needs are being met from the clinic by assessing: 1) does the clinic provide interpretation and 2) does the clinic have a process that has been easily communicated to the members? After this we will create an action plan, if needed.

The REALD data we are using is below in Tables 3, 4 and 5. We intend to review data on member language and race to compare member assignments to PCPCH and non-PCPCH clinics. We want to ensure members' language interpretation needs are being met regardless of the clinic they are assigned to. The REALD data shared in the tables below are sourced from the OHA 834 enrollment file and we know many members do not complete this information in their OHP application. Therefore, we want to work with our PCPCH clinics to collect REALD information for those patients that might not have reported their language and/or their interpretation need. We already work closely with our PCPCH clinics around data reporting and will be reviewing REALD standards including the importance of asking and explaining to patients why we collect this data. For our non-PCPCH clinics, we would need to explore how to build this kind of data collection and reporting infrastructure.

Table 3: PCPCH and Non-PCPCH clinics/Tiers by Member Language

PCPCH by Language

Ref Name	PCPCH Tier: Not PCPCH Recognized	Tier 3	Tier 4	5 STAR
Not provided		5.6%	94.4%	
Arabic			100.0%	
Bosnian			100.0%	
Burmese			100.0%	
Chinese	100.0%			
En			100.0%	
English	3.8%	9.8%	72.7%	13.8%
English Assumed		25.0%	75.0%	
French			100.0%	
Gujarati			100.0%	
I do not want to answer	1.1%	16.9%	75.3%	6.7%
Khmer			50.0%	50.0%
Korean		14.3%	71.4%	14.3%
Other	5.1%	6.8%	77.1%	11.0%
Panjabi			100.0%	
Portuguese			100.0%	
Sign Language			100.0%	
Simplified Chinese		25.0%	75.0%	
Spanish	0.8%	7.8%	77.4%	14.0%
Spanish Assumed			100.0%	
Tagalog			66.7%	33.3%
Thai			33.3%	66.7%
Traditional Chinese	25.0%		75.0%	
Undetermined	1.2%	4.9%	84.1%	9.8%
Yue Chinese			100.0%	

% of Total Distinct count of Mbr_id (copy) broken down by PCPCH Tier vs. Ref Name. The data is filtered on cco and ccotype. The cco filter keeps Columbia Pacific. The ccotype filter keeps A and B.

Table 4: Interpreter needs in PCPCH/Non-PCPCH clinics.

PCPCH by Language (2)

interpreter..	PCPCH Tier: Not PCPCH Recognized	Tier 3	Tier 4	5 STAR
Unknown	3.7%	9.7%	72.8%	13.8%
Yes	0.6%	7.2%	79.5%	12.8%

% of Total Distinct count of Mbr_id (copy) broken down by PCPCH Tier vs. interpreterneeded. The data is filtered on cco and ccotype. The cco filter keeps Columbia Pacific. The ccotype filter keeps A and B.

Table 5: Race identification in PCPCH/Non-PCPCH clinics

PCPCH by Race

	PCPCH Tier			
Race (group)	Not PCPCH Recognized	Tier 3	Tier 4	5 STAR
American Indian or Alaskan Native	4.6%	12.5%	73.3%	9.5%
Asian or Pacific Islander	3.7%	11.7%	66.1%	18.5%
Black or African American	3.4%	6.3%	76.0%	14.3%
Hispanic	2.2%	8.5%	76.1%	13.2%
Native Hawaiian or Pacific Islander	0.9%	9.3%	75.3%	14.4%
Not Provided	3.8%	11.8%	72.0%	12.4%
Other Race or Ethnicity	3.3%	10.0%	73.2%	13.5%
White	3.8%	9.2%	72.8%	14.2%

% of Total Distinct count of Mbr_id (copy) broken down by PCPCH Tier vs. Race (group). The data is filtered on cco and ccotype. The cco filter keeps Columbia Pacific. The ccotype filter keeps A and B.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Outreach and education to clinics to influence Tier advancement

☒ Short term or ☐ Long term

Monitoring measure 1.1	Outreach to Tier-3 clinics			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
5 Tier 3 clinics	Outreach to 5 clinics	08/2023	Complete outreach for 5 clinics	08/2023

Activity 2 description: Outreach and education to non-PCPCH recognized clinics to ensure language barriers are being addressed.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Analyze interpretation and language needs			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No outreach to members/clinics in the non-PCPCH clinics that have interpretation needs	Complete outreach to non-PCPCH clinics to ensure language interpretation policies and procedures are in place for assigned members	09/2023	All clinics who have assigned CPCCO members with language assistance needs have policies and procedures in place to procure language interpreters for scheduling and visits	09/2024.

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 73: Improved access to grievances and appeals for members with Limited English Proficiency

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

If continued, insert unique project ID from OHA: 73

B. Components addressed

a. Component 1: Grievance and appeal system
b. Component 2 (if applicable): CLAS standards
c. Component 3 (if applicable): Health equity: Data
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? 14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In the last year, CPCCO has focused our attention on assessing and addressing internal barriers to our grievances and appeals process to make it more linguistically accessible to members with limited English proficiency (LEP). CPCCO's grievances and appeals process is a centralized service provided by CareOregon on behalf of CPCCO and is operationalized by staff from many departments across the organization. This presents many opportunities to identify areas that may be creating barriers for our members. So far, our internal review has illuminated opportunities to improve data analysis capability, as well as external strategies to increase pathways to submit grievances for members with LEP.

2022 was the second consecutive year that CPCCO has pulled grievances data disaggregated by race, ethnicity, and language. Right now, this data is our primary source to assess the cultural and linguistic accessibility of our grievances and appeals processes.

Grievances by Race and Ethnicity, 2021 & 2022

Race or Ethnicity	2021 CPCCO Enrollment %	2021 Grievances %	2022 Enrollment %	2022 Grievances %
American Indian or Alaska Native	1.6%	0.9%	1.7%	0.0%
Asian, Native Hawaiian, Pacific Islander	1.1%	0.9%	1.4%	1.2%
Black or African American	0.8%	0.0%	0.9%	0.0%
Hispanic or Latina/o/e/x	9.6%	5.6%	9.1%	3.7%
Not Provided	19.1%	18.5%	17.3%	9.9%
Other Race or Ethnicity	1.3%	1.9%	2.1%	1.2%
White	66.5%	72.2%	67.4%	84.0%

Grievances by Language, 2021 & 2022

Language	2021 CPCCO Enrollment %	2021 Grievances %	2022 Enrollment %	2022 Grievances %
English	93.8%	100.0%	94.65%	98.77%
Spanish	4.8%	0.0%	4.45%	1.23%
Undetermined	1.3%	0.0%	0.48%	0.00%
Other	0.1%	0.0%	0.30%	0.00%
Additional languages*			0.12%	0.00%

**"Additional languages" in 2022 Grievances by Language data includes the following languages: Arabic (8 members), Korean (7), Traditional Chinese (4), Thai (4), Tagalog (3), Yue Chinese (2), Khmer (2), Punjabi/Panjabi (2), Chinese (2), Bosnian (1), Burmese (1), French (1), Lao (1), Gujarati (1), Sign Language (1), Portuguese (1)*

In 2021, CPCCO identified disparities between the percentage of enrolled CPCCO members and the distribution of grievances submitted by race, ethnicity, and language. In 2022 this disparity persists, although it is promising that CPCCO did receive one grievance submitted in Spanish which suggests that the process is at least conceivable to navigate for some members with LEP. Continued monitoring and evaluation of this data will offer a better analysis of trends over time, and whether our processes are truly becoming more culturally and linguistically accessible.

Based on our internal review of our grievances & appeals operations, as well as a review of CPCCO grievance and appeals data, several gaps have emerged which we intend to address through this project:

- Substantial disparities persist between the percentage of enrolled CPCCO members, and the distribution of grievances submitted by race, ethnicity, and language. Notably, only 1.75% (which amounts to one grievance) was submitted in Spanish, and zero grievances were submitted in any other language besides English. In addition, zero grievances were submitted in 2022 from American Indian/Alaska Native or Black/African American members.
- As mentioned above, continued monitoring and evaluation of this data is required to offer a more comprehensive analysis of trends over time.
- We do not currently have a process in place to map grievances and appeals data to CPCCO member SOGI data to identify and address inequities that may exist for these populations.
- CareOregon's current internal process to pull and analyze grievances and appeals data is problematic. In the existing process, Excel spreadsheets are used to manually manage and analyze data. This creates opportunities for error, such as formulas "breaking," data corruption or loss, inconsistencies, and subjecting data to potential manipulation (intentional or unintentional). The existing process also makes pulling, accessing, and analyzing data extremely cumbersome and time intensive, which inhibits our capacity to monitor data more frequently, or develop more nuanced and detailed data analysis.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In our 2022 TQS report, CPCCO identified two activities and corresponding monitoring measures for this project:

2022 Activity 1*: Monitor longitudinal trends in grievances and appeals data by race, ethnicity, and language.*

- ***Monitoring measure 1.1****: Quality, cadence, and target audience of grievance and appeals data reports.*

- ***Target:*** *Annual cadence of G&A data depicts year-over-year data to monitor trends over time.*
- ***Benchmark:*** *Annual G&A data shared with CACs, CAP, and extended BOD.*

CPCCO is making progress on this activity as we continue to build a regular practice around monitoring our grievances and appeals data. 2022 marked the second consecutive year that grievances and appeals data was presented to the Network and Quality Committee of CPCCO's Board of Directors (BOD), contributing to our target of developing a cadence of reviewing this data on an annual basis. CPCCO is also becoming more comprehensive in the grievances and appeals data we review. 2022 was the first year that CPCCO pulled data specific to Notice of Adverse Benefit Determination (NOABD) and Appeals, which are also important data points to examine disparities that may exist in our processes. This data was also shared with the Network and Quality Committee during their annual review. With only two years of data so far, it is difficult to depict trends over time, but we hope to be able to move in that direction with continued monitoring.

Pertaining to the benchmark future state, we have reconsidered the need to present this data directly to the full BOD or the Clinical Advisory Panel (CAP) on an annual basis, as we gain better clarity around the role of the Network and Quality Committee. The purpose of the Network and Quality Committee is to provide oversight of and assure compliance with the CCO's quality program, transformational quality strategies, network adequacy and external quality review audits. The Committee also provides consultation to and assures adequacy of clinical quality improvement activities under the purview of CPCCO's Clinical Advisory Panel as needed. The Committee's Charter explicitly identifies appeals and grievances as one of the primary responsibilities of the group (*Network and Quality Committee Charter 2022,* see additional attachments in Section 3). Thus, we decided that sharing grievances and appeals data with the full BOD or CAP on an annual basis would be redundant and undermine the role of the Network and Quality Committee itself. Gaining better clarity of our audiences and roles and responsibilities related to this data is improvement, but we have a continued opportunity to incorporate the sharing of this data with our clinical advisory councils (CACs), which we did not complete in 2022.

Grievances by Race and Ethnicity, calendar year 2022

Race or ethnicity	# Enrollment by Race/Ethnicity	% Enrollment by Race/Ethnicity	# Grievances by Unique Member	% Grievances by Unique Member
American Indian or Alaska Native	689	1.7%	0	0.0%
Asian, Native Hawaiian, Pacific Islander	574	1.4%	1	1.2%
Black or African American	355	0.9%	0	0.0%
Hispanic or Latina/o/e/x	3658	9.1%	3	3.7%
Not Provided	6977	17.3%	8	9.9%
Other Race or Ethnicity	855	2.1%	1	1.2%
White	27120	67.4%	68	84.0%
Totals	*40228*		*81*	

Notice of Adverse Benefit Determination (NOABD) and Appeals by Race and Ethnicity, calendar year 2022

	# NOABDs	% NOABDs	# Appeals	% Appeals
American Indian or Alaska Native	45	1.6%	1	1.1%
Asian, Native Hawaiian, Pacific Islander	30	1.1%	1	1.1%
Black or African American	26	0.9%	0	0.0%
Hispanic or Latina/o/e/x	143	5.0%	2	2.2%
Not Provided	411	14.4%	12	13.5%
Other Race or Ethnicity	67	2.3%	1	1.1%
White	2133	74.7%	72	80.9%
Totals	*40228*		*81*	

Notice of Adverse Benefit Determination (NOABD) and Appeals by Language, calendar year 2022

	# NOABDs	% NOABDs	# Appeals	% Appeals
English	2767	96.92%	89	100.00%
Spanish	61	2.14%	0	0.00%
Undetermined	17	0.60%	0	0.00%
Other	5	0.18%	0	0.00%
Additional languages*	5	0.18%	0	0.00%
Totals	*2855*		*89*	

**"Additional languages" in 2022 Grievances by Language data includes the following languages: Arabic (8 members), Korean (7), Traditional Chinese (4), Thai (4), Tagalog (3), Yue Chinese (2), Khmer (2), Punjabi/Panjabi (2), Chinese (2), Bosnian (1), Burmese (1), French (1), Lao (1), Gujarati (1), Sign Language (1), Portuguese (1)*

Lessons learned: As the second year pulling and sharing disaggregated grievances and appeals data, we have come to better appreciate the difficulty of our current data management process. The existing process, if left unchanged, will greatly inhibit our ability to meaningfully analyze trends over time.

Our data management process has also created barriers to our ability to share this data with the CACs. Because our process is highly manual and time consuming, the availability of this data is limited, putting constraints on

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our ability to be flexible or adaptable. With rigidity in timing, it has not been possible to fit this topic in with the CACs against other competing priorities of regulatory responsibilities that the CAC must attend to.

Change in focus: Success related to this activity is twofold: 1) our ability to manage and pull data; and 2) our data sharing practices with the Network and Quality Committee and with the CACs. Since we have identified our data management practices as a major barrier, we plan to differentiate that need as a separate activity related to our grievances and appeals project (described below). We will also keep this activity but revise the focus to: *Develop data sharing practices that monitor and build accountability for existing disparities in our grievances and appeals processes.*

***2022 Activity 2**: Assessing internal grievances and appeals process and identify institutional barriers impacting linguistic accessibility for members with LEP.*

- ***Monitoring measure 2.1**: Map the end-to-end process for submitting and processing grievances and appeals.*
- ***Target:** Map and document G&A processes.*
- ***Monitoring measure 2.2**: Identify institutional barriers impacting linguistic accessibility for members with LEP.*
- ***Target:** Internal barriers identified and documented.*
- ***Benchmark:** Action plans in place to address barriers.*

CPCCO has made progress in better understanding our internal operations for managing our grievances and appeals processes and identifying barriers that may impact accessibility for members with LEP. While the end-to-end process has not been formally mapped, the beginning of our internal review flagged two major barriers which now have action plans underway to address them.

As mentioned above, the first barrier identified was CareOregon's current internal process to pull and analyze grievances and appeals data. In the existing process, Excel spreadsheets are used to manually manage and analyze data. This creates opportunities for error, such as formulas "breaking," data corruption or loss, inconsistencies, and subjecting data to potential manipulation (intentional or unintentional). The existing process also makes pulling, accessing, and analyzing data extremely cumbersome and time intensive, which inhibits our capacity to monitor data more frequently, or develop more nuanced and sophisticated data analysis. To address this barrier, CareOregon has put an action plan in place to configure a nationally recognized and utilized module for managing grievances and appeals data. This Appeals and Grievances Workflow Module will utilize the same software used for CareOregon's Call Tracking and Claims processing, allowing for greater integration across data sources.

The second barrier identified was the availability of multiple pathways to submit grievances in Spanish, and the challenge to LEP members to navigate our grievances process. To reduce the impact of this barrier, CareOregon has developed a "Member Complaint/Feedback Form" that is available in multiple languages, may be completed in any language, and that may be completed on behalf of a member by an advocate or representative with a community-based organization (CBO) (*Member Complaint/Feedback Form,* attached). Currently, the form is available in English and in Spanish on our website. Widespread dissemination and training on how to use the form is the next step in this action plan.

Lessons learned: We have recognized how central data is to our ability to monitor this work and assess the impact of our interventions. While pulling data once a year is a start, without sophisticated software for collecting, pulling, and analyzing data over time, we are limited in our ability to improve our system in a way that can be measured.

Change in Focus: Since two prominent barriers have been identified, we are going to refocus our activities on addressing those barriers. As such, the final two activities we will focus on in the next year will be: 1) *Improve data management practices to support meaningful analysis of existing disparities in CPCCO's grievances and appeals processes.*; and 2) *Implement and enculturate the use of our Member Complaint/Feedback Form to increase pathways to submit grievances for members with LEP.*

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In the coming year, CPCCO intends to focus our appeals and grievances process improvement activities in three areas:

Activity 1: ***Develop data sharing practices that monitor and build accountability for existing disparities in our grievances and appeals processes.***

While we have managed to share grievances and appeals data with the Network and Quality Committee of the BOD for two years now, we still have a lot of room for improvement to build data sharing practices that illuminate and build accountability for existing disparities. In the next year, we will again share appeals and grievances data with the Network and Quality Committee and will be more intentional to ensure this data also makes it to the CACs for review. With both governance bodies, there is also an opportunity to discuss accountability toward progress and define what that means for the Board's Network & Quality Committee and the CACs to hold CPCCO accountable to the accessibility of our grievances and appeals processes, beyond simply reviewing data every year.

This activity addresses our grievances and appeals system component as well as CLAS standard #14: *Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints*. Without ongoing and meaningful monitoring of data, we would have no way of examining the accessibility of our processes, and no mechanism to practice accountability for reducing and eliminating disparities. Sharing this data and accountability with our CACs is particularly supportive of CLAS standard #14 because CPCCO's CACs include representatives from the Latinx community, and are now fully bilingual entities, enabling participation from members with LEP, and sharpening feedback related to cultural and linguistic accessibility.

Activity 2: ***Improve data management practices to support meaningful analysis of existing disparities in CPCCO's grievances and appeals processes.***

In 2023, we plan to configure an Appeals and Grievances Workflow Module. This module will utilize the same software used for CareOregon's Call Tracking and Claims processing, allowing for greater integration across data sources, and will manage appeals and grievances by electronically routing them through CareOregon processes. The Module will allow for electronic auditing and create a more secure location for appeals and grievances work.

Once configured, staff will be trained to use the module efficiently, and reports will be developed. Initially, reports will focus on regulatory requirements such as a Grievance/Appeal Log, but as the module is refined, the use of attributions will allow for better, more consistent reporting.

This activity addresses our grievances and appeals system component as well as CLAS standard #14: *Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints*. The ability to pull accurate consistent data is a prerequisite to monitoring

data, which as mentioned above, is essential to examine existing disparities and practice accountability for the accessibility of our processes. With the new Module, we will be able to pull appeals and grievances data with greater consistency and predictability that is easily replicable and will be less subject to manipulation. Our current data practices also do not provide the possibility to eventually integrate our grievances and appeals data to CPCCO member SOGI data. Without this ability we have little awareness of the disparities related to submitting grievances and appeals that may exist for these populations. With the added ability to manage larger data sets, and greater integration with CareOregon's claims processing software, the Module may also increase our prospective capacity to add SOGI data to our standard data monitoring practices. Once SOGI standards are available through OAR in summer 2023, we will explore how this data may be integrated into our grievances and appeals data reporting and monitoring to identify disparities and inform quality improvement efforts.

Activity 3: ***Implement and enculturate the use of our Member Complaint/Feedback Form to increase pathways to submit grievances for members with LEP.***

In 2023, we will bring our "Member Complaint/Feedback Form" to our CACs for feedback and to begin socializing this initiative as an opportunity to increase pathways available for members with LEP to submit grievances. After socializing with the CACs, we hope to facilitate widespread dissemination of this form to CBOs in our region, coupled with training to facilitate advocacy on behalf of our members with LEP. We hope that with widespread adoption at local CBOs, members with LEP can be supported to navigate the process to submit grievances, and do so either in the language they prefer, or with the support of an advocate who can complete the form on their behalf.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Develop data sharing practices that monitor and build accountability for existing disparities in CPCCO's grievances and appeals processes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	*Data sharing cadence and practices with the Network and Quality Committee (N&Q) and the Community Advisory Councils (CACs).*			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data shared annually with N&Q Committee of BOD	Data shared in 2023 with CACs in addition to N&Q	12/2023	Longitudinal data shared annually with N&Q and CACs	12/2024

Activity 2 description: Improve data management practices to support meaningful analysis of existing disparities in CPCCO's grievances and appeals processes.

☐ Short term or ☒ Long term

Monitoring measure 2.1	*Implementation of Appeals and Grievances Workflow Module.*

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Manual data management via Excel Spreadsheets	Implement Appeals and Grievances Workflow Module	12/2023	Refine current process to review and analyze data annually disaggregated by REALD and SOGI	12/2024

Activity 3 description: Implement and enculturate the use of our Member Complaint/Feedback Form to increase pathways to submit grievances for members with LEP.

☒ Short term or ☐ Long term

Monitoring measure 2.1	*Socialization and dissemination of Member Complaint/Feedback Form.*			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Form developed but not socialized	Form socialized with CACs	06/2023	Form disseminated to CBOs with training	12/2023

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 417: Improving Behavioral Health Access: Expansion & Integration of Behavioral Health Services in additional outpatient settings

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

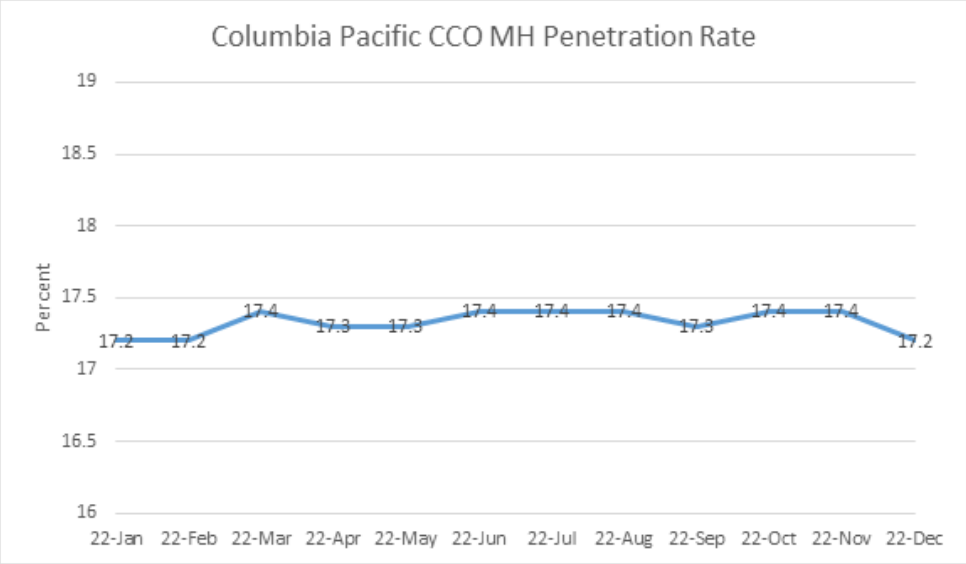
If continued, insert unique project ID from OHA: 417

B. Components addressed

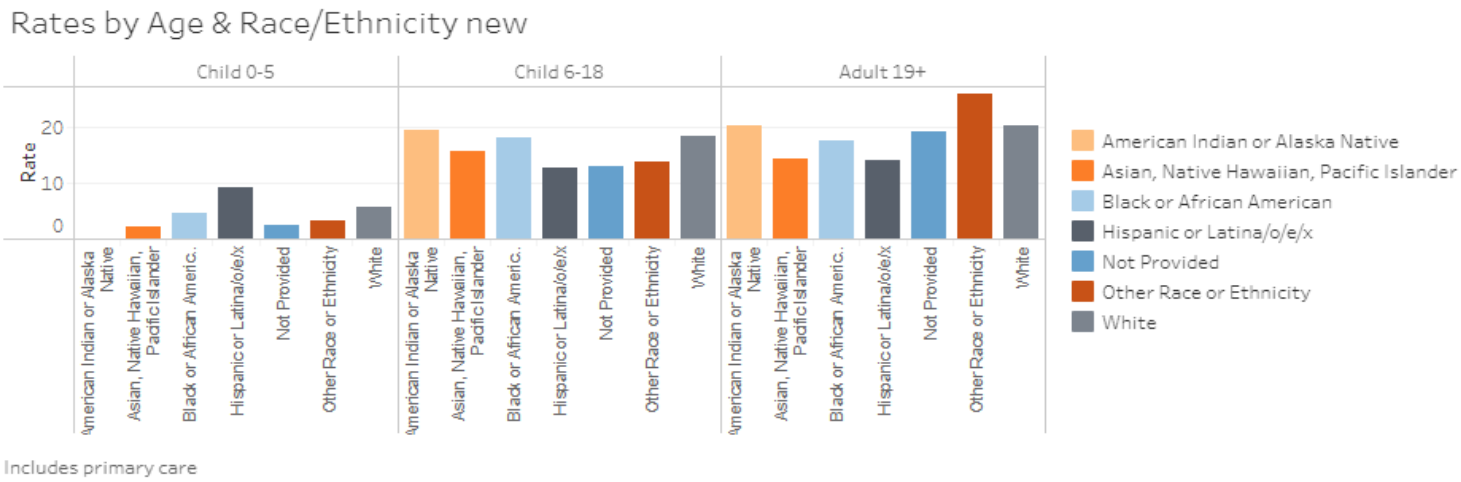
a. Component 1: Behavioral health integration
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

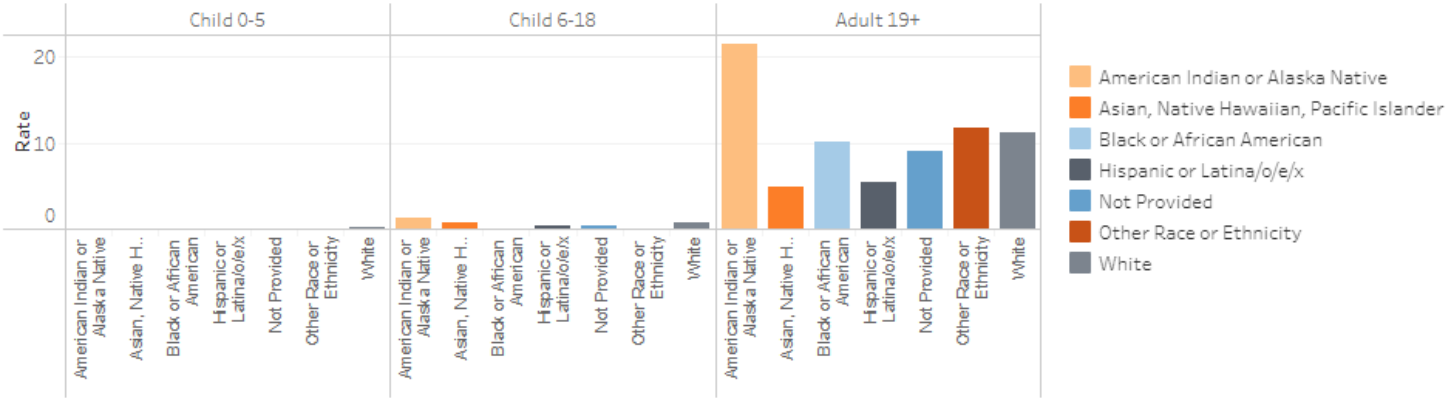
Columbia Pacific CCO has seen a decline in mental health services utilization from 2021 to 2022. In January of 2021 we had a penetration rate of 18.87% for all of CPCCO's members and that rate had declined to 17.1% by the end of the year. The rate has held steady around 17% for all of 2022:



Digging in deeper into those rates, we see that youth use of behavioral health services is much lower than our adult utilization. This data mirrors feedback we have received from our network partners who reported inadequate behavioral health supports for school-aged and below school-aged youth.



SUD Penetration Rates



D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

For 2022, CPCCO was focused on identifying our target populations, the clinical model that would best suit these priority populations with the development of a toolkit to help primary care implement that model, and an evaluation of payment models to sustainably support this work on an ongoing basis.

2022 Activity 1: Define priority population focus for behavioral health services in primary care and build technical assistance toolkit for providers to implement population-driven strategies for delivering direct behavioral health services and supporting bi-directional referrals to more specialized outpatient behavioral health services.

Monitoring Measure 1.1: Define population strategy with priority populations and clinical cut-offs for retaining members in behavioral health services in primary care versus referring to specialized outpatient behavioral health services.

- ***Target***: Priority populations identified and agreed upon by network. Established strategy with identified priority populations and clinical criteria for referral.

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- ***Baseline***: No strategy with clinical referral criteria. No priority populations identified on which to focus BH service expansion in primary care.

Monitoring Measure 1.2: Develop toolkit to support behavioral health integration and bi-directional referral process.

- ***Target:*** Clinical model developed (focusing on above priority populations) and toolkit developed.
- ***Baseline:*** No clinical model or toolkit developed to support primary care in implementation.

2022 Activity 2: Research and develop alternative payment glidepath to support the expansion of behavioral health services in primary care.

Monitoring Measure 2.1: Evaluate current state of payments for behavioral health services in primary care.

- ***Target:*** Payment evaluation complete.
- ***Baseline:*** No evaluation complete.

Monitoring Measure 2.2: Develop alternative payment glidepath for behavioral health in primary care.

- ***Target:*** Alternative payment model created.
- ***Baseline:*** No alternative payment model created.

Monitoring Measure: 3.1: Deliver technical assistance support to primary care organizations on behavioral health
integration/expansion using newly developed toolkit.

- ***Target:*** 4 clinics receive technical assistance.
- ***Baseline:*** No clinics receiving technical assistance.

Monitoring Measure: 3.2: Execute new contracts for alternative payments to primary care providers delivering expanded levels of integrated behavioral health services.

- ***Target***: 2 executed contracts.
- ***Baseline***: No executed contracts.

CPCCO held leadership meetings with various primary care and hospital systems to solicit interest in intentionally building out more FTE capacity for more traditional co-located therapy, in addition to the integrated behavioral health consultation that we had already established. By mid-2022, these efforts had been completed but limited progress was made following this solicitation. The network was limited in staffing and capacity due to Covid and did not readily respond to our solicitations. Despite this, some clear themes emerged from these conversations.

The first theme was that expanding behavioral health into primary care was not grounded in data showing that this was a meaningful leverage point. Partners proposed school-based health centers, urgent walk-in clinics, or the emergency department as preferred settings to focus on. The second theme was that we couldn't lead with a defined clinical model and simply expect network adoption. Rather, we needed to listen to what the community had identified as their priorities, augment their lived experience with data analysis, and then collaborate on the clinical model that would be the solution. The final theme was that if we wanted the network to collaborate better and have bi-directional referrals then we needed to address the administrative needs of our network and the lack of supports that prevented them from collaborating in such a manner.

CPCCO responded to this feedback by pivoting efforts for behavioral health integration to expansion in school-based and hospital-based services and increasing telehealth providers in the region. We had started conversations with Columbia Memorial and Providence Seaside Hospitals who both identified a desire to expand

outpatient behavioral services but also did not yet have capacity to begin planning any expansion efforts in 2022. CPCCO found more momentum in school-based service expansion and telehealth.

CPCCO collaborated and funded an expansion of Columbia Health Services' (CHS) school based mental health program; this increased mental health services from two schools -- Clatskanie Middle and High Schools -- to eight additional schools, including elementary and middle schools throughout Columbia County. This expansion increased services from one school and one walk-in clinic in Columbia County to having 10 clinicians across school districts in five cities (Clatskanie, Rainier, Scappoose, St. Helens, and Vernonia) with an additional clinician in the walk-in center to serve families with children aged 0-5. To ensure sustainable growth, CHS has used a phased approach to their expansion. Phase one (August-December 2022) included hiring and training staff, building data reporting, and building internal infrastructure.

All benchmarks were met apart from some vacancies unfilled clinical positions. To address this gap, CHS has been actively recruiting for these vacancies, including hosting job fairs, and offering relocation assistance to applicants. Phase two (January-June 2023) includes completing hiring, credentialing, training, implementing group therapy in schools, and completing a data review for baseline health data. Phase three (July 2023- June 2024) includes quality improvement review, and data reporting out of EPIC. In reviewing pre and post claims data for services CHS has provided, there has been a significant increase in youth served, even with current vacancies in staffing. September 2021- January 2022 showed 19 unique members serviced versus 61 unique members served during the same period after the expansion contract was executed (September 2022- January 13, 2023). The number of total claims also increased significantly from 48 to 281 during this period.

In Tillamook County we found that the network's focus was on retaining psychiatric services. To support Tillamook County Community Health Center (TCCHC) after their staff psychiatrist left the region, we secured a telehealth contract with Brightways, a culturally responsive provider in the Portland metro area. We were able to create expedited referrals for members with TCCHC to access Brightways' medication management services while continuing to maintain a connection to TCCHC for in-person services. Our Brightways contract and an additional contract with Charlie Health also enhanced our ability to provide additional options for culturally specific services, increased services for youth (specifically increased access to intensive outpatient), and additional medication management options. We introduced both providers to our local network partners so they could begin building referral pathways and also shared their information at various learning collaboratives.

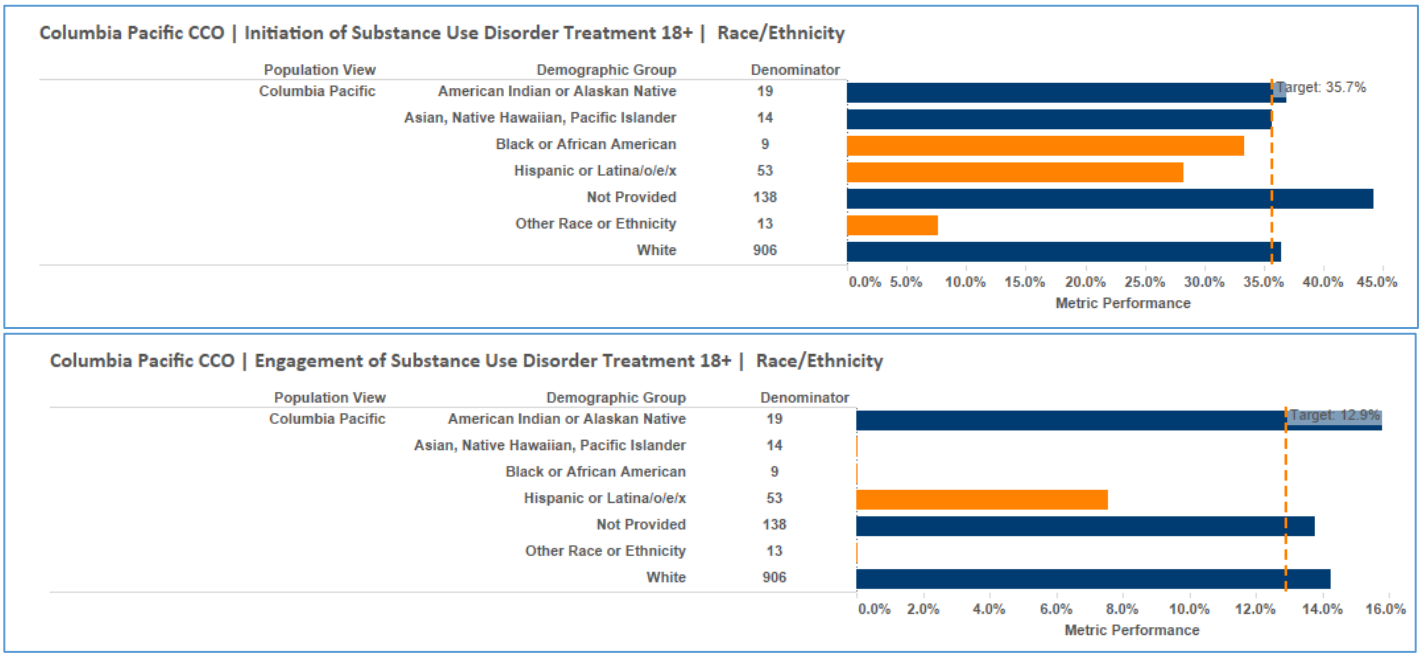
While we had to pivot to a more collaborative and partner-specific approach, we believe our work with CHS and telehealth was still aligned with our original monitoring activities of identifying priority populations, creating sustainable payment pathways, and providing technical assistance to support integration of the new clinical services into the existing network. In communication with our network, we identified youth and members needing medication management as priority populations. We work with these partners to secure contracts with sustainable funding options. In the case of CHS, we collaborated with them on their phased approach to begin with capacity building funds that would pivot to sustainable funding once their clinicians were in place. We also had a strong focus on supporting the development of referral pathways and shared understanding of referral criteria. For telehealth, this focused on referral pathways for culturally specific services and expedited referrals for medication management. For CHS, the emphasis was on referral pathways to Columbia Community Mental Health for WRAP and/or higher levels of care.

We also focused on providing technical assistance on bi-directional referrals for the rest of our network partners. Last year we provided bi-directional referral technical assistance in our Quality Improvement Workgroup (QIW), a collaborative meeting we host each month for our primary care partners, as a focused agenda for 2022. We invited all the Community Mental Health Programs (CMHPs) in the region -- Clatsop Behavioral Health, Columbia Community Mental Health and Tillamook Family Counseling Center-- and CODA for medication-assistant treatment collaboration in the region—to strengthen the relationships between our primary care clinics and the

community mental health providers. Every other month in QIW was a focused substance use disorder (SUD) activity to influence engagement around the topics below:

- February: SBIRT, Alcohol Use Disorder, Opioid Use Disorder, process improvement understanding and tools, introductions to CMHP partners, and new metrics
- April: SBIRT rate 2, and Primary Care/CMHP bi-directional activity
- August: Bi-directional referrals and panel discussion among each county (Primary Care/CMHP)
- October: County breakouts, guest speaker on peer support specialists (Becky Wilkinson – BOB), and OCHIN workflows

We believe this support aided our Initiation and Engagement to Treatment metric in 2022 (see data below) and built more time for those to have discussions about the referral process.



E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

While there has been some increased network stability achieved in 2022, the behavioral health network has continued to be significantly impacted by the pandemic and workforce shortages. With significant changes in leadership, staffing, and services for the region, CPCCO will need to complete a reassessment of the health and adequacy for the behavioral health network. This reassessment will include 1) assessing availability for all covered behavioral health benefits, 2) completing a quality review for these services, and 3) determining how to shift outpatient services to other parts of the network to allow for more focused specialty services within the Community Mental Health Programs.

We will also continue goals and interventions identified as priorities: 1) promote the expansion of behavioral health services in additional outpatient settings, and 2) continuing bi-direction referral pathways for substance use disorders between Primary Care, specialized behavioral health services, and outpatient/telehealth providers. We will also focus on building out the administrative capacities of our CMHPs. For this we will promote and support the roll out of the Strategic HealthCare Investment for Transformation (SHIFT) program to create high performing behavioral health homes that reduce health disparities and are member centered.

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Priority populations identified for these projects will be members with substance use disorder and/or severe mental illness, and families inclusive of youth and maternity needs. We will also be gathering more information around subpopulations in these areas to determine which groups are having higher health disparities. Once identified, work will focus on how to change interventions, processes, and programs to reduce health inequities.

SHIFT will begin a phased roll out, starting in February 2023 with the creation of a Learning and Advisory Council. The advisory body will seek applications from community stakeholders from the region, including primary care, community mental health programs, and practitioners with experience in clinic transformation. The advisory council will launch in April 2023 and focus on defining core operational components for SHIFT. The second phase of the rollout will begin in late 2023. Organizations will be invited to apply to be included the first cohort and will begin to receive operational supports from SHIFT.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Promote and support network engagement in SHIFT program

☐ Short term or ☒ Long term

Monitoring measure 1.1	Launch SHIFT advisory council and/or first cohort.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No advisory council or program cohorts	Launch program and advisory council	12/2023	Launch first program cohort	01/2024
Monitoring measure 1.2	Support rural partner engagement in SHIFT program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No CPCCO network involvement in SHIFT	Network actively engaged in SHIFT	01/2024	Network engagement in SHIFT sustained	01/2025

Activity 2 description: Explore investment opportunities and build capabilities of community mental health programs to engage in bi-directional referrals and collect, report, and analyze data on general service utilization and referral practices.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Reporting & referral workflow assessment

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current state assessment of reporting & referral workflows	Current state assessment conducted	08/2023	Support plan developed based on assessment results	12/2023

Activity 3 description: Complete an assessment of the capability and adequacy of the behavioral health network and identify opportunities to further invest in increasing behavioral health.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Capability and adequacy assessment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No assessment of availability for all covered behavioral health benefits and quality of those services	Current state assessment conducted	08/2023	Support plan developed based on assessment results	12/2023

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 416: Meaningful Language Access

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

If continued, insert unique project ID from OHA: 416

B. Components addressed

a. Component 1: CLAS standards
b. Component 2 (if applicable): Health equity: Cultural responsiveness
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

In 2022, we analyzed utilization data from our interpretation vendors and discovered we have very low utilization in our region. This led us to do an environmental scan of our network's contracted interpretation vendors and learned that many of our partners had contracts with the same vendors. Conversations with our primary care clinics revealed that they were not aware that they could be reimbursed for their interpretation visits when they use a shared vendor. We then worked throughout 2022 to build awareness amongst our primary care network of their ability to bill CPCCO for these services. We believed increasing their utilization of our vendors would help us collect more accurate data on interpretation utilization in our region. However, we also realized we still needed to work on collecting data directly from our clinics to develop a fuller picture on interpretation utilization. To gather more data from our network, we continued having CareOregon do chart reviews of claims that had an interpreter flag. We also built a phased approach to collecting data via our Primary Care Payment Model (PCPM) and other value-based payment arrangements, beginning in 2019, to incentivize our clinics to report interpretation data and build infrastructure in their clinics to provide the quality care these members need. Phase one of the Meaningful Language Access (MLA) reporting required responses to assessment questions related to policies and procedures as well as a quantitative data reporting element. The assessment element includes 3 parts, outlined below, with questions similar to those asked on the CCO Incentive Metric self-assessment. In the 2022-2023 program, visit level data reporting was a new requirement. We have 9 clinic systems reporting in MLA as of 2022.

Assessment:

- Part 1: Identification and Assessment for Communication Needs
- Part 2: Provision of Language Access Services
- Part 3: Number of Visits in which member was flagged as needing interpreter services

Visit Level Data:
For the visit level data, we use the "needs interpretation" flag from the OHP application provided by OHA via the 834-enrollment file to identify members with language interpretation needs and all their primary care visits. For the PCPM program, clinics must report on visits for members assigned to their clinic with a "needs interpretation" flag and where they were the pay-to-provider on the claim. We provide a list of these visits and ask that reporting clinics provide details about interpretation services in a format matching OHA's metric reporting format.

CareOregon provides:

- Member ID
- Visit type/Care Setting
- Visit Date

Organizations must report:

- Interpretation visit modality (In-person, telephonic, video remote), if provided
- Interpreter OHA certified and qualified information if interpretation provided
- Interpretation Vendor, if used
- Interpretation provided by bilingual staff
- Member refusal and reasoning

Results of Data Collection:

The collective learning from our chart reviews, clinic data submissions, and vendor reports was that the biggest area for improvement was in data collection. We found that a significant proportion of the data was missing necessary documentation across all domains. Our belief is that if we focus on workflows for better documentation of interpretation, we will also be creating more visibility within the network of the needs for interpretation by our members. The charts below demonstrate the breadth of this issue.

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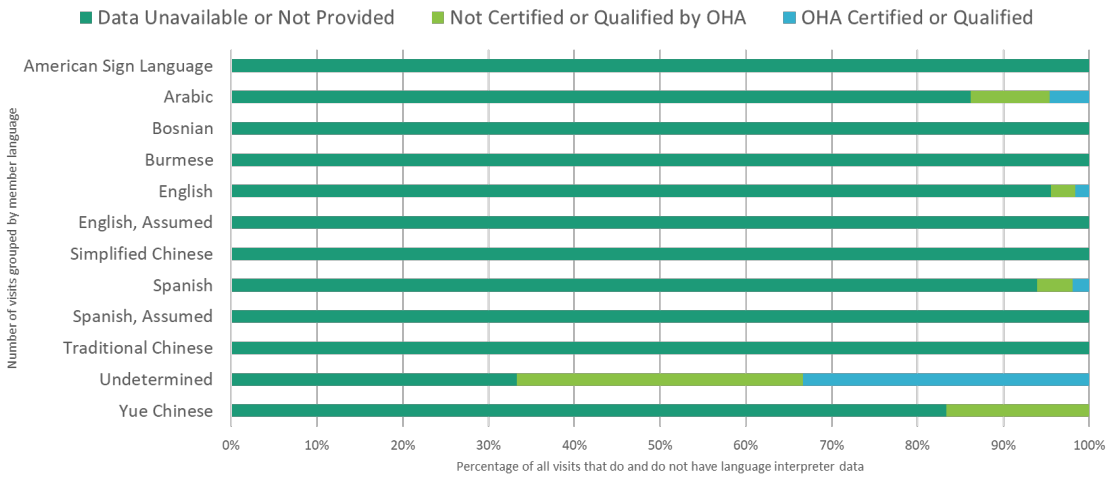

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2022, we made progress by recognizing regional strengths and gaps that members face as we work to support improvement, and that were in the next stage of our MLA interventions. However, we needed to identify specific gaps where we can provide intervention. This recognition supported our decision to complete an internal current state analysis to help us identify those specific interventions and overall regional need in 2023.

To begin, we created a PCPM summary to identify those clinics that are lacking quality workflows or additional infrastructure to collect data. The PCPM performance summary includes clinic system's MLA reporting for the measurement period January 1st – June 30th, 2022.

The needs recognized from the PCPM performance were:

- An opportunity to provide specific in-depth technical assistance to our clinics by reviewing workflows and systems for tracking language supportive services for the members that need this language interpretation (i.e., language interpretation vendors, certified/qualified status, or bilingual staff).
- An opportunity to provide technical assistance for their reporting to CPCCO and analyze the information they collect in their EMR.

We also provided technical assistance in two collaborative venues this past year: our Clinical Advisory Panel (CAP) and Quality Improvement Workgroup (QIW). We asked for advice and championship in our CAP, an official CPCCO governance body that has members ranging from Medical Directors to Quality Directors and other multi-disciplinary clinical leaders in our region representing the clinic systems and overall regional needs. Quality Improvement Workgroup (QIW) is another venue to support change and improvement in primary care because the professionals that are invited are the people who generally lead initiatives/changes and provide policies and workflows changes that are specific to clinical staff. The following are the opportunities we provided for CAP and QIW.

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CAP

April 2022: Recapping the MLA metric and needs to report. We asked about their needs and how they interpret the importance of specific components required. They reported to us that the most important aspect (summarized) is to provide improvement, standardization and help capturing required data.

December 2022: Reminding the panel that we have upstream measures that we are focusing on in 2023 and that MLA is one of those that we will focus on as it is our 3rd year working on this measure.

QIW

May 2022: Recapping the MLA work and resources in the region and reminding them of the vendors we have available that they can bill CPCCO for the services they provide. We decided to support their needs via our every other month clinical meetings.

December 2022: Reiterating to the workgroup that we would provide technical assistance for their reporting needs and that CPCCO is working on an assessment tool or opportunity to assess workflows with the clinic's participation – focusing on data, workflows/policies/SOP's, CLAS standards, equity Lens, and interpretation needs.

Our targets and benchmarks from last year were:

Activity 1: Building an infrastructure to collect data on interpretation services as well as improve the quality of accessing those services. We met this target with all the organizations who are incentivized to report this information from our PCPM. We exceeded our monitoring measure to collect data from at least 7 clinics by receiving data from all 9 clinics that participate in the program. We have learned that clinics need more support defining and completing the visit-level interpretation data element.

Activity 2: Assess and begin to improve interpretation services workflows within the Columbia Pacific CCO primary care network. This has not yet been met, and we would like to consider this a long-term project. We learned the assessment we designed to understand barriers via workflows is too large and cumbersome for the clinics. We are considering capacity as a primary reason as they were struggling to hire professionals in the region.

Activity 3: Development of clinic-level interpretation toolkit. We did meet this monitoring measure. Our team was able to complete an interpretation toolkit, which is continuing to be used by our technical assistance staff.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In Q1 2023 we plan to finish our current state analysis so we can develop our work plan outlining technical assistance focus areas for improvement in Q2-Q4. The current state analysis will be informed by the following:

- Language interpretation data from clinics (EMR, workflows, PCPM).
    - This includes visit-level detail from the second PCPM reporting, which is due February 28th, 2023 (January 2022 – December 2022)
- Assessment of each clinic's gaps and strengths for staff learning and training, patient education, communication and materials, workflows, documentation, evaluation, and overall organizational commitment using the CLAS standards and Health Equity Culture.

Some supportive strategies we anticipate developing include creating and maintaining a vendor data workflow,

PCPM reporting workflow, and mechanism to consistently track clinics' quality improvement activities related to language interpretation services.

In addition to clinic technical assistance, we will be analyzing our REALD data to identify interventions and opportunities to serve patients' needs. One complication we are finding in our data is a discordance between members' indicated primary and spoken language and indication of needing language interpretation. We see in our member data individuals who indicated on their OHP application that they need language interpretation but then their primary language and spoken languages are listed as English or not at all. Furthermore, we have members whose primary language is listed as something other than English, but they did not indicate they need language interpretation. To better understand our members' language interpretation needs we are attempting to crosswalk the 834 language information with the data collected through our PCPM and our language interpretation vendor contracts. In particular, we are examining two groups of individuals:

- Members who indicated they need language interpretation and whose primary language is listed as "English" or "Unknown" or "I do not want to answer" - we are asking clinics to report through the PCPM the members' requested language for interpretation and/or whether interpretation is refused because the member confirms the MMIS interpretation needs flag is incorrect (Table 1)
- Members whose primary language from the OHP application is listed as something other than English and did not indicate they need language interpretation – we are looking at our language vendor data to see if any members are receiving language interpretation and if so, for what language (Table 2)

Table 1: Counts of Spoken Language for Members Who Indicated They Need Language Interpretation Services on their OHP Application – Sorted by County of Assigned Primary Care Clinic

	Assigned PCP (group)				
Language Description	Clatsop County Clinics	Clinics outside CPCCO region	Columbia County Clinics	Tillamook County Clinics	Grand Total
Spanish	383	27	61	103	574
English	30	1	12	5	48
Arabic	1		7		8
Simplified Chinese			3	2	5
Panjabi	2				2
Traditional Chinese				1	1
Thai			1		1
Spanish Assumed				1	1
English Assumed			1		1
Burmese	1				1
Bosnian			1		1

Distinct count of Mbr id (copy) broken down by Assigned PCP (group) vs. Language Description. The data is filtered on Cco, Enroll Status, Assigned PCP and interpreterneeded. The Cco filter keeps Columbia Pacific. The Enroll Status filter keeps Active. The Assigned PCP filter keeps 22 of 386 members. The interpreterneeded filter keeps 1. The view is filtered on Language Description, which excludes Null.

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Table 2: Counts of members who received language interpretation through our vendor contracts (Q4 2021 – Q3 2022) grouped by whether they indicated a need for language interpretation on their OHP application

Member Spoken Language	Count of services for members whose MMIS flag indicated a need for interpretation	Count of services for members who did NOT have a MMIS flag indicating a need for interpretation
Arabic (ARA)	5	
Libyan Arabic (AYL)	5	
Burmese (BUR, MYA)	2	
English (ENG)	9	37
Unavailable/ Unknown/ Undetermined	70	106
Simplified Chinese (QBA)	1	
Russian (RUS)		1
Spanish (SPA)	65	80
Yue Chinese (YUE)		1
Chinese (ZHO)	1	1

The population of focus is members with limited English proficiency and/or those who would benefit from interpretive services.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Build an infrastructure for data review and technical assistance plan by: 1) Identifying clinic reporting needs to accurately report for 2023 CCO incentive metric and 2) Refining the monitoring process for PCPM data collection review and action planning

☒ Short term or ☐ Long term

Monitoring measure 1.1	Clinic reporting needs assessment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 clinic systems' needs assessed	5 clinic systems' needs assessed	06/2023	9 clinic systems' needs assessed	09/2023.

Monitoring measure 1.2	PCPM data collection review and action planning refinement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data review without action planning	Data review incorporating action planning	09/2023	Data review incorporating action planning	09/2023

Activity 2 description: Identify interpretation services needs through clinic workflow assessment

☒ Short term or ☐ Long term

Monitoring measure 2.1	Interpreter services workflow assessment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No assessment	Assessment conducted in 5 clinics	09/2023	Needs identified in 5 clinics through assessment results	12/2023

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 421: Oral Health Services in Primary Care

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

If continued, insert unique project ID from OHA: 421

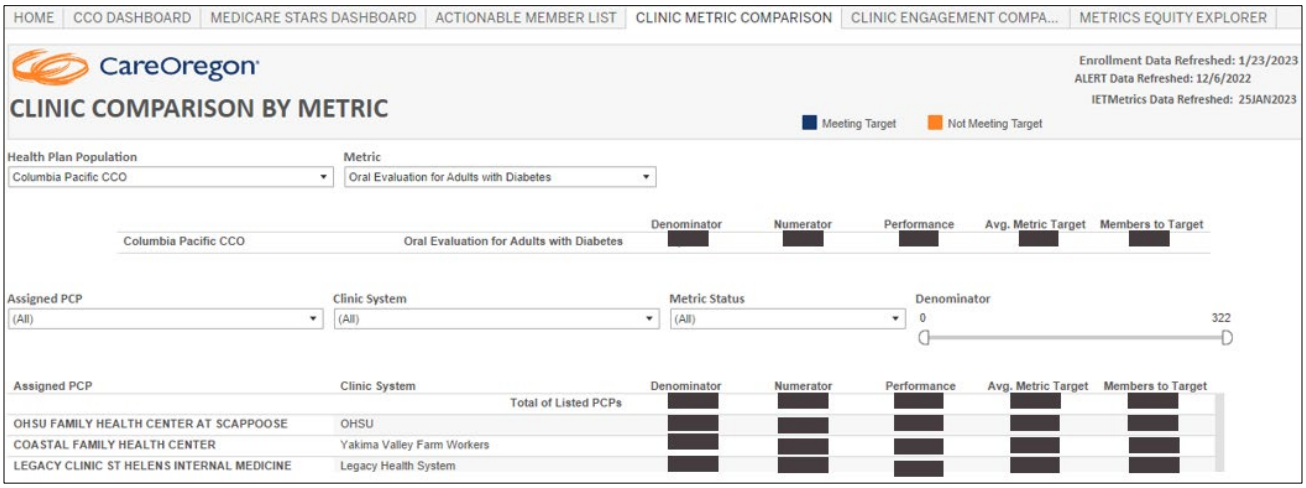
B. Components addressed

a. Component 1: Oral health integration
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

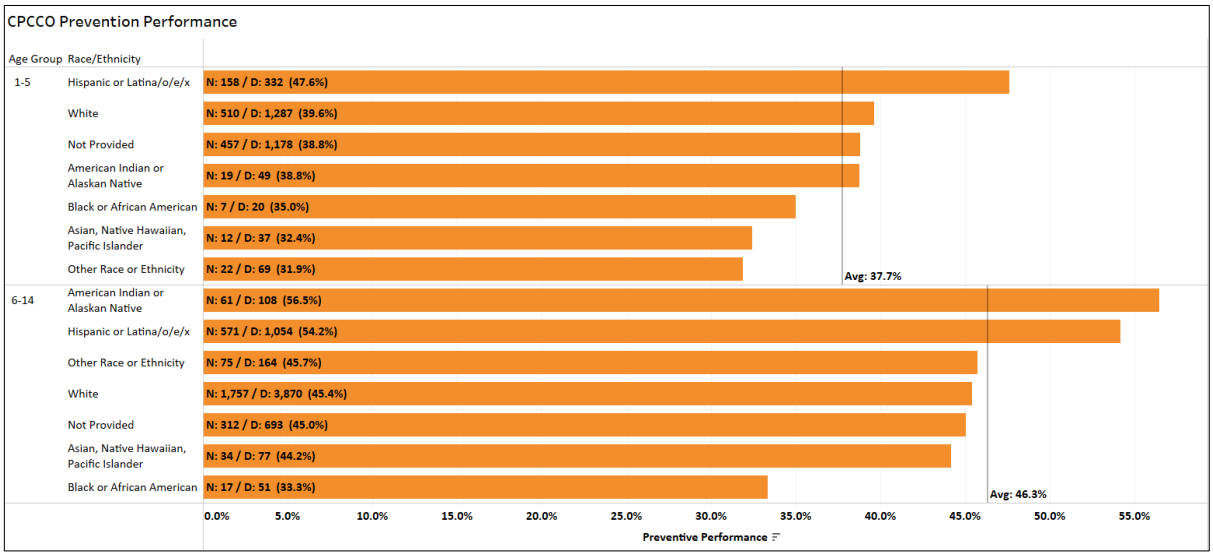
C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Oral health integration initiatives continued to move forward even with staffing and bandwidth impacts due to the public health emergency. Our focus has been to improve access points outside of the dental setting and increase data sharing to support population health outcomes.

- The biggest accomplishment to date for this component is the development of our comprehensive maternity, pediatric, and diabetes oral health integration toolkits for CCO staff and physical health network providers. The toolkits are the ultimate guide for workflow development, benefit explanations, and member and provider-facing resources. The pediatric oral health integration toolkit has been shared with OHA's Affinity Group leadership for dissemination with their CMS partners.
- A portfolio of pediatric oral health educational and navigational materials was developed for both primary care providers and members. Materials have been shared with partners and are available in either web-friendly or printed versions. Both the member and provider resources have been added to the CPCCO website and are also included in the integration toolkit.
- Primary Care Providers (PCP) were given access to an enrollment dashboard that identifies the member's dental plan assignment and last date of dental visit along with other data. This key information supports dental navigation and provides the PCP with additional dental health information.
- We successfully added dental data to Primary Care Provider dashboards in Q4 2022. Diabetes data had been identified as the first HIT enhancement to be completed. The addition of the diabetes oral evaluation data set is a continuation of the previous 2020-2021 TQS. The addition of pediatric dental engagement data for prevention services to PCP dashboards has been slated as the second data set to be added. Dental data on the external PCP dashboards include dental visit information, preventive dental services metric data and dental plan/clinic assignment. Provider sites have received upskilling to the new dashboard data, in addition to oral health resources that support connecting a member to dental care.



- The largest and most complex activity for the oral health component is the HIT enhancement to improve our dental care referral platform and bidirectional communication. This enterprise-wide project has been secured with CareOregon Executive Leadership as a priority to ultimately improve dental access and utilization of services for our members. Cross-departmental teams are working to automate and optimize the current process. The goal is to improve referral data sharing with Dental Care Organizations for all dental care coordination lists, including the dental care requests, and to improve the referring PCP's ability to access referral outreach and visit completion data in efforts to move to a closed loop system.
- CareOregon is building a Member Table data source that will have all sources of data for race, ethnicity, language, and disability. One of those sources being the REALD data source. The multiple sources of demographic data enable us to meet various reporting needs and analysis. Analysis needs vary depending on program, services, or population. It also enables us to compare across data sources and identify errors that we may be able to improve. CareOregon has an enterprise-wide dashboard that allows users to access demographic information of our members at a population (aggregate) view or at a member level view. When SOGI data is available we can add this information to this dashboard. This dashboard is the most highly utilized dashboard at CareOregon. It is considered a source of truth on member information.
- All CPCCO dental dashboards include available data on race/ethnicity and language. Below is a sample of 2022 claims data through mid-December for members ages 1-14 who received a preventive dental service stratified by race/ethnicity:



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D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

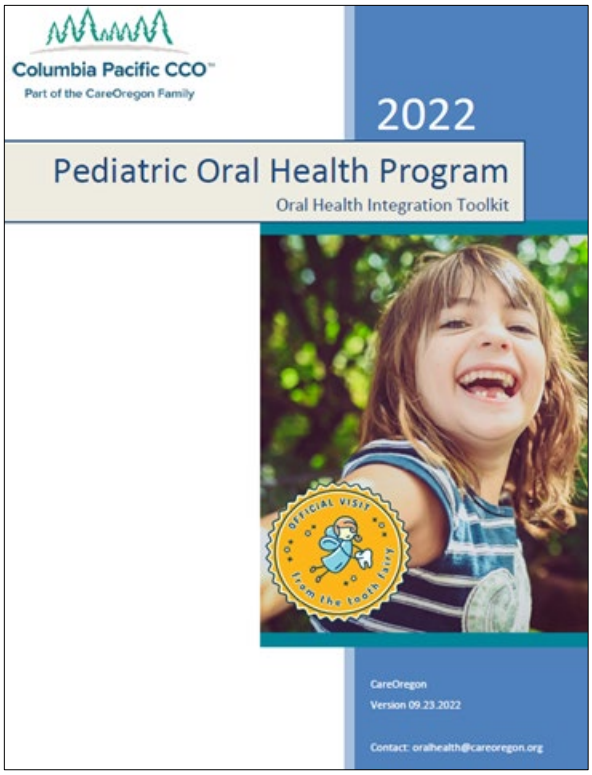
Columbia Pacific CCO made great strides with this oral health integration (OHI) project, focusing on the delivery of oral health services outside of traditional dental settings. We recognize that the most impactful integration efforts, screening, fluoride varnish application and referral, lie in well child visits. In addition to providing services within primary care, we are creating pathways for more efficient and transparent data sharing between health care providers to support members' total health.

One of the biggest learnings from the review of our 2022 TQS was our over ambitious timeframes. In reviewing our progress and year to date accomplishments, we noted that the past year focused on creating the foundational support needed to move this work forward. Examples include the high-quality integration toolkits in which we dedicated time and resources to create the most value-add tool for partners. As we delved into scoping of the large enterprise-wide bidirectional referral HIT enhancement, project management required additional steps, planning and cross-departmental support not previously anticipated. In the 2023 brief narrative section you will see we extend project activities to ensure that we will have a better final product.

Progress to date on last year's goals include:

Activity 1: Oral Health in Primary Care: Develop and share a robust pediatric oral health integration toolkit for CCO staff and network providers.

- Monitoring Measure 1.1: The target to develop the toolkit was met.
- Monitoring Measure 1.2: The target to distribute toolkits with technical assistance to four provider sites was met.



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Activity 2: Enhancing HIT: Add dental engagement data to PCP dashboards. Data to include dental visit information, preventive dental services metric data and dental plan/clinic assignment.

- Monitoring Measure 2.1: The addition of actionable preventive pediatric dental data on PCP dashboards was not met by the target timeline due to competing priorities and resource limitations. The first data set added was for members with diabetes. The work to add preventive dental services metric data to the PCP dashboards is in progress.
- Monitoring Measure 2.2: The target date is April 2023; this work to train PCPs on the use of the actionable dashboard is in progress.

Activity 3: Enhancing HIT: Work with the analytics team to determine the number and percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit, and to develop a data dashboard visualization.

- Monitoring Measure 3.1: The completion of a dashboard to visualize dental care requests was not finalized by December 2022. This is part of the larger bidirectional referral project to optimize our current dental care referral platform and bidirectional communication. Analytics work will begin once the platform updates have been implemented.
- Monitoring Measure 3.2: We have not yet analyzed and monitored the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request to create an improvement over baseline. This target date is April 2023. We continue to work on this as part of the bidirectional referral project.

Activity 4: Oral health outside of dental settings: Analysis of dental services in physical health claims for quality improvement. This work has 2023 targets and is currently in process.

- Monitoring Measure 4.1: Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2023. The target date for this activity is March 2023. This work is in progress.
- Monitoring Measure 4.2: Dental claims in physical health data analysis developed and reported. The target date for this activity is June 2023. This work will begin once 2022 performance is final.
- Monitoring Measure 4.3: Deliver findings and resources for quality improvement to four (4) provider sites. The target date for this activity is December 2023. This work will begin once the 2022 data reports are completed and ready to share with partners along with integration resources.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

We understand that primary care teams have multiple demanding priorities for provision of care during a short visit time. Provider buy-in is essential for the successful implementation of integration practices. We strive to make oral health integration an easy lift and as seamless as possible for network partners. Our integration and dental navigation tools, with targeted trainings, help advance the knowledge and awareness of primary care teams on the importance of oral health for children ages 1-14 years. We also aim to improve dental navigation and dental visit adherence with the ultimate goal of increasing dental utilization and lowering the incidence of dental caries. Now that we have current and historical claims and dental care request data from multiple partners, we are positioned to implement thorough and meaningful data analysis practices for quality improvement with an equity lens. The PCP children's preventive dental services dashboard is our own health information technology tool designed to further strengthen integration efforts. This dashboard transmits basic dental health data points to PCPs and includes information on their members' dental needs they did not previously have easy access to. Training on the use of the dashboard, with oral health messaging and dental navigation tools, will be designed to make the data actionable for partners and support member outcomes. Continued PCP training, utilization, and spread of the dental care request form builds communication pathways for care coordination with dental plans. This health plan support addresses a gap identified in navigation to

dental services where the burden often falls on the PCP and patient to understand and navigate the complexities of the benefit structure. Continuation of HIT enhancement to improve our dental care referral platform and bidirectional communication is key to support member care. Data analytics and dashboard buildout on the percentage of children who had a dental care request form submitted by the physical health provider and who completed a dental visit may provide insight on gaps within the navigation system, health disparities and/or access concerns. This will allow for data-driven conversations and improvement activities with PCP and dental plan partners on timely access to care. Analysis of covered oral health services in primary care, such as screening or assessment and fluoride varnish claims data to understand variability in data and determine strong and underperforming clinics will allow for shared learning and additional technical assistance. Additionally, an analysis of dental care requests resulting in a completed dental visit stratified by member race and language will aid in identifying and addressing health disparities for the aforementioned pediatric members ages 1-14.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Enhancing HIT: Add dental engagement data to PCP dashboards. Data to include dental visit information, preventive dental services metric data by PCP and dental plan/clinic assignment

☐ Short term or ☒ Long term

Monitoring measure 1.1	Addition of actionable dental data on PCP dashboards			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Dental data not on PCP dashboard	Dental data added to PCP dashboard	10/2023	Dental data added to PCP dashboard	10/2023
Monitoring measure 1.2	PCPs trained on the use of the actionable dashboard			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No provider sites trained	Four (4) provider sites trained	04/2024	Four (4) provider sites trained	04/2024

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

☐ Short term or ☒ Long term

Monitoring measure 2.1	Completion of a dashboard to visualize dental care requests			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Dashboard not available	Dashboard created	12/2023	Dashboard created	12/2023
Monitoring measure 2.2	Analyze and monitor the number and percentage of dental care requests for children that result in a completed dental visit within 30, 60, and 90 days of the request.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline not available	Determine 2023 baseline and future improvement target set.	04/2024	Baseline determined and future improvement target set.	04/2024

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

☐ Short term or ☒ Long term

Monitoring measure 3.1	Determine baseline performance at the PCP-level of sites applying fluoride varnish in primary care and determine an improvement target for fluoride varnish applications in 2024.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Baseline performance data not available	Baseline determined	03/2024 (to allow for claims runout)	Baseline determined	03/2024 (to allow for claims runout)
No improvement target set	2024 improvement target set	03/2024 (to allow for claims runout)	2024 improvement target set	03/2024 (to allow for claims runout)
Monitoring measure 3.2	Dental claims in physical health data analysis developed and reported			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data analysis	Data fully analyzed with accompanying findings and progress report	06/2024	Data fully analyzed with accompanying findings and progress report	06/2024
Monitoring measure 3.3	Deliver provider findings and resources for quality improvement			

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No findings available	Findings and resources delivered to four (4) provider sites	12/2024	Findings and resources delivered to four (4) provider sites	12/2024

Activity 4 description: Addressing health disparities: Analysis of dental care requests resulting in a completed dental visit stratified by member race and language.

☐ Short term or ☒ Long term

Monitoring measure 4.1	Stratification of dental care requests by race and language within data visualizations			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Stratification data (REAL_D) available, not currently combined with dental care request data	Stratification data (REAL_D) combined with dental care request data	06/2025	Stratification data (REAL_D) combined with dental care request data	06/2025

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Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 80: Trauma Informed Network

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

If continued, insert unique project ID from OHA: 80

B. Components addressed

a. Component 1: Social determinants of health & equity
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☐ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

The most recent OHA child health complexity data (2021) indicates high levels of childhood risk factors including high levels of (parent) mental health challenges -- 43.4% in Columbia County and 37.9% in Clatsop County -- and high levels of parent SUD -- 29% in Columbia County and 24% in Clatsop County. In particular, all of the key Columbia County OHA indicators (child poverty, foster care, parental incarceration, parent mental health, parent SUD) are either over or equal to the state average in all 5 indicators collected. All of these factors are also independently considered Adverse Childhood Events (ACEs). In line with this current finding, the most recent BRFSS data (2014-2017) indicates that ACEs are elevated in Clatsop County, with 23.7% of adults having 4 or more ACEs, compared to 22.3% for the state of Oregon and 15.8% nationally. ACEs are also elevated in Columbia County, with 18.2% of adults having 4 or more ACEs, compared to 22.3% for the state of Oregon and 15.8% nationally. We suspect that the BRFSS estimate that one in five (1:5) Oregonians have experienced four or more ACEs is a low estimate both statewide and in our region.

In terms of REALD data, according to the U.S. Census Bureau's most recent population estimates (2022) for Columbia County, 92.1% of the population identifies as white with .8% identifying as Black, 1.6% American Indian, 1.1% Asian and 4.1% two or more races. About 6.2% of the population identifies as Latino. 12.1% of the population under 65 lives with a disability. 3.3% of the population speaks a language other than English at home.

For Clatsop County, 92.2% of the population identifies as white with 1% identifying as Black, 1.4% as American Indian, 1.7% Asian and 3.4% two or more races. About 9.2% of the population identifies as Latino. 12.8% of the population under 65 lives with a disability. About 6.4% of the population speaks a language other than English at home.

Neither the OHA data nor the BRFSS data at the county level is disaggregated into REALD or SOGI categories. Data for our target population at the county level is often either limited or not available, or not available for sub-groups such as children ages 0-5. We are collecting data ourselves because key data sets, such as resiliency, which are the positive factors that help you recover from and heal trauma and mitigate the risks, were simply not available in the target populations. In the data that we are collecting ourselves for our baseline and

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resiliency measurements using the Child and Youth Resilience Measures (CYRM), we are collecting REALD data, SOGI data and 0-5 data wherever possible. However please note that REALD and SOGI data collection is sensitive in the target counties as the numbers are often small for particular sub-groups, especially when disaggregated by other factors as well, and thus cannot always be reported due to privacy and safety considerations.

The target communities are conservative and there has been some push back against gathering SOGI data in some school districts. For example, we were asked to remove SOGI related questions from surveys in certain school districts. The agreed upon compromise was that students could leave questions blank, if they so desired, although it is not yet clear if that school district will move forward with the survey. Despite this, some of the network member organizations work directly with the LGBTQIA+ children and their parents. LGBTQIA+ is a vulnerable population we seek to support, and we gather relevant data whenever possible.

Other significant social context indicators include high rates of school children are chronically absent, especially when compared with national averages: 20.5% of Columbia County school children are chronically absent compared with 20.4% for the state of Oregon and 16% nationally. 18.5% of Clatsop County school children are chronically absent compared with 20.4% for the state of Oregon and 16% nationally. This data is collected by the Dept. of Education, and they do disaggregate by REALD. In general, across the different school districts, children of color, English language learners and those with disabilities were more likely to be chronically absent.

In terms of social context, Columbia Pacific CCO held a participative community process in each county in 2019 to create strategic plans which were approved by each network in 2020. These participatory processes engaged local health service providers, school districts, community organizations, non-profits, local government agencies and community members in determining the most pressing needs and priority areas for trauma informed and resiliency building efforts in each county. Additional gaps/needs identified through this process include food assistance, access to childcare, transportation, and social supports for parents. Additional needs particularly noted since then by community members due to the COVID-19 pandemic and isolation include access to mental health services.

As part of the project, Columbia Pacific CCO is supporting network member organizations to put together projects to address the community needs from each strategic plan that they see as being most important. The Community Resilience and Trauma Informed Care Impact Fund is specifically designed to fund projects from our strategic plan for each county. The purpose of the Impact Fund is to help the networks become self-sufficient and sustainable and to bring local efforts into alignment by supporting projects congruent to the network strategies, shared measures, and agenda. The fund will be administered by the Oregon Community Foundation. For more information, please see below the update on activity # 3. Please find the strategic plans as well as population data indicators attached for each county as Appendix A, Appendix B, Appendix C and Appendix D.

In general, community members choose to utilize population data whenever possible rather than child health complexity data as it only includes OHP members. However, where population data is not available, we will use child health complexity data.

Columbia Pacific CCO has also identified availability of affordable housing as a key issue in the target communities and is addressing housing insecurity by helping leverage state/federal funding for building affordable housing units. Additionally, suicide prevention and increasing access to traditional health worker projects in both counties help OHP members access resources, care, and culturally appropriate care for those who might otherwise not feel comfortable in accessing health care.

Columbia Pacific CCO has been in contact with Advanced Health including presenting about this project and our learnings at an OHA conference and we also connected with them individually to discuss their experience and learnings. We will continue to follow-up to share learnings and experiences.

Additionally, specific areas of data related to the project not currently available including resiliency measures and trauma informed care will be collected in the target areas. As data collection is a significant project involving many stakeholders, it is taking time. However, we hope to complete the baseline data collection in 2023.

In 2018 CPCCO's Board of Directors voted to hire a Senior Program Development Specialist to establish county-level networks tasked with finding interdisciplinary approaches to building resilience and implementing trauma-informed policies, programs, and best practices across sectors at a community level. One of the long-term goals of the network is to improve quality of care and services to improve outcomes for children and families and improved resilience that buffers the health and social effects of adversity.

Outreach, recruitment, and community education about the trauma informed networks continued throughout 2022. By January 2023, 27 organizations in Clatsop County and 34 in Columbia County had formally joined the networks by signing a letter of commitment. Please see the list of member organizations for each county, attached as Appendix E and F. Columbia Pacific CCO continued to support sector workgroups in each county by working with sector workgroup co-chairs to facilitate and convene monthly meetings in 2022.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2018, community engagement staff at Columbia Pacific CCO facilitated a roadshow of the findings of its community health assessment at events where participants from a range of backgrounds including OHP members and Community Advisory Council members were asked to vote on what the CCO should set as their Community Health Improvement Plan priorities. Of the 147 people who voted across the 15 events, 55% voted that trauma-informed care should be CPCCO's number one priority, which is more than double the share of the vote of the second highest priority. The Community Advisory Councils have consistently recommended it be a chief priority in the Improvement Plan and in practice as well, often supporting trainings and events, but desiring a more systematic response.

As a community-based, partner-reliant strategy, these networks must be built "at the speed of trust" to be effective. As such, the time since Board approval and specialist hire in 2018, work has focused on trust-building including:

- Gathering national, state, and local data from sources such as BRFSS, the DHS County Data Books, the Department of Education, and more. This data focused on what is known around specific Adverse Childhood Experiences, as well as known signs that ACEs are prevalent such as health and social outcomes.
- Gathering community input from a variety of local viewpoints representing needs across sectors.
- Sharing resources, data, and research about the importance of building resilience and the impact of ACEs locally.
- Building and nurturing relationships with community partners in Clatsop and Columbia counties.
- Working with partners to build strategic plans that highlight data as the basis for action and establish strategies, interventions, desired outcomes, and indicators of success.

This body of work takes a long view because by its nature it is an intervention that focuses on upstream strategies and interventions. This means it may be multiple years, or even generations, before the benefits of the work are demonstrated by population-level or CCO-level data. As such, a variety of process measures are mixed in with longer- term indicators chosen to help demonstrate progress and included in the logic models.

In 2022, with the support of Columbia Pacific CCO, sector workgroups in both counties began baseline data collection using the Child and Youth Resilience Measure (CYRM). The CYRM tools measures the positive factors that help children overcome stress and challenges, thus promoting resilience. The tool will be administered to children ages 5 – 9 and 9 – 23 across both counties with the support of the school districts. The goal is to collect the data every five years to allow schools to target interventions, seek funding with our support and see changes. Sector workgroups are also collecting secondary data from various sources related to the network strategic plan indicators. This data will be collected every other year once the strategic plan initiatives are implemented to monitor progress. A dashboard was created to track the network strategic plan indicators and lives on the website, so community members can see if the networks are reducing trauma and building resilience in the target communities.

Additionally, CPCCO with the support of TIO, collected TIC baseline data from member organizations across both counties. Network member organizations completed the TIC baseline survey from March - May 2022. The intent of the TIC baseline survey is to collect baseline information for where people feel their organization is with TIC. The survey tool is based on individual perceptions about their organization. Network member organizations that took the survey were advised that those who take the survey be proportionate to different positions and power in their organization. For example, that the survey be administered among leadership, staff, and service/program beneficiaries. The survey tool outlines a developmental approach across four TIC phases. Phase 1: Trauma Aware, Phase 2: Trauma Sensitive, Phase 3: Trauma Responsive and Phase 4: Trauma Informed. Out of 144 survey respondents from 30 Columbia County network member organizations, 25.7% indicated that their organization is in phase 2 (i.e., trauma sensitive) and 19.4% indicated that they are in phase 1 (i.e., trauma aware). Out of 171 survey respondents from 22 Clatsop County network member organizations, 29.7% indicated that their organization is in phase 2 (i.e., trauma sensitive) and 20.9% indicated that they are in phase 1 (i.e., trauma aware). While these scores are based on perception, this range of responses suggests that the network member organizations in both counties consist of a mix of veteran organizations that have been deeply engaged in TIC implementation and organizations that are newer to TIC and have just started on this journey.

An annual update specific to activities reported on last year are provided below.

Activity 1: Offer trauma informed, ACEs and resiliency-building training across sectors with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia counties. The training will be held virtually due to current pandemic conditions. As such, it will be possible to hold just one training and reach both counties. Activity 1 was successfully completed.

In April 2022, Columbia Pacific CCO brought in Trauma Informed Oregon (TIO) to train network member organizations from both counties via Zoom on the "Science of Trauma." Priority to participate in the training was given to organizations and service providers who serve vulnerable populations in Clatsop and Columbia counties. A rapid self-assessment survey was sent to network member organizations in both counties to identify their needs and training level in Trauma Informed Care (TIC), and Diversity, Equity, and Inclusion (DEI). Based on this input, TIO designed a training to meet their needs. The training covered the science of trauma, TIC, and was grounded in N.E.A.R (Neurobiology, Epigenetics, Adverse Childhood Experiences, and Resilience) science and included interactive learning to apply the concepts taught. In total, 100 participants from both counties participated in the training. TIO administered a pre and post-test to measure understanding growth in the following items:

- I understand how knowledge of NEAR science can help strengthen families and communities.
- I understand how trauma, chronic stress, and adversity affect brain development, behavior, and the capacity to learn in children.
- I understand practical TIC applications (you feel you can go out and apply what you learned about TIC relatively quickly).

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Of the 86 participants who took the pre and post-test, 35.3% reported an increase in their knowledge of how NEAR science can help strengthen families and communities and 10% reported an increase in their knowledge of how trauma, chronic stress, and adversity affect brain development, behavior, and the capacity to learn in children. Additionally, 28.6% reported an increase in their knowledge confidence of practical TIC applications. The average total scores increased 36.9%. A make-up training took place in May 2022. In total, 20 additional people participated bringing the total trained to 120 participants.

Activity 2: Offer 8 workshops to trauma informed care champions and core teams within network member organizations to help them implement trauma informed approaches in their own organizations with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia counties. These practical follow-up trainings will support member organizations to develop their own plans to adopt trauma informed practices. Activity 2 was successfully completed.

Between May and July 2022 Columbia Pacific CCO offered 8 practical follow-up workshops/conversations to 40 trauma informed care champions and core teams members within the network member organizations to help them implement trauma informed approaches with a special focus on member organizations and service providers who serve vulnerable populations. These practical follow-up workshops/conversations were facilitated by TIO and took place in each sector work group so that organizations could learn from and work together with their peer organizations in each sector. The workshops/conversations focused on arming member organizations with the knowledge to accurately assess their own organizations to see how they are currently doing in terms of trauma informed care and then prepare to adopt and implement trauma informed approaches by providing information about the TIO Trauma Informed Care (TIC) Implementation Tool and how organizations can roll it out.

The TIC Implementation Tool provides a framework for incorporating trauma informed policies, practices and care into any organization's structure and can help track progress over time. The sector workgroups also discussed how to use the results from the TIC Implementation Tool to move the goals of the group forward and some sector workgroup members worked together to help each other access funding for additional support/accompaniment throughout the process. Member organizations were receptive and excited to begin administering the TIC Implementation Tool assessment in 2023 in their organizations and developing their own plans to adopt trauma informed practices. 40 champions trained. All participants increased practical knowledge of adopting and implementing trauma informed.

Activity 3: Develop and establish the Trauma Informed Care (TIC) and Resilience Fund. Activity 3 was successfully completed.

The purpose of the TIC and Resilience Fund is to help the trauma informed networks in Clatsop and Columbia counties move towards becoming self-sufficient and sustainable. The TIC and Resilience Fund will support projects from the network strategic plans. Columbia Pacific CCO will contract with a foundation to administer the Fund and will coordinate together closely to put the fund infrastructure into place. Columbia Pacific CCO will support each steering committee to develop a clear and transparent grant review process and to serve as the grant review committee for their county.

To help the trauma informed networks move towards becoming self-sufficient and sustainable, the Columbia Pacific CCO Board of Directors approved funding in June 2022 to establish the Community Resilience and Trauma Informed Care Impact Fund and contributed an initial investment of $400,000. The fund will be administered by the Oregon Community Foundation (OCF). Each county has access to $200,000 for the 2023 – 2024 funding cycle to fund projects from their strategic plans that address childhood trauma and build resilience in children and their families. The vision is to sustain the fund by leveraging Columbia Pacific CCO's contribution to secure additional funding commitments from foundations, private donors and member organizations. Columbia Pacific CCO supported each steering committee to develop and approve a formal grant application, grant review

committee guidelines and a scoring system to rate grantee applications in the fall of 2022. Each network steering committee will act as a grant review committee and will decide who gets funded and for what amount in each county. Network member organizations have been invited to apply. As of this writing, an LOA between OCF and Columbia Pacific CCO has been signed. The goal is for the application to go live on the OCF website the first quarter of 2023 and the first grants to be disbursed later in 2023.

Activity 4: Develop two websites, one for each network, to facilitate the work of the networks in each county and to help community members and organizations connect with and learn about the networks, childhood
trauma and building resilience. Activity 4 was successfully completed.

Columbia Pacific CCO helped design and facilitate a process by which the networks created a website for each county. The purpose of each website is to help facilitate the work of the networks in each county and to help community members and organizations connect with and learn about the networks. Ideas that were generated by the groups were shared with a web developer who in turn developed each website. Once the websites were completed, the websites were previewed across all sector workgroups and the steering committees for a second round of feedback and ideas. Concurrently, Columbia Pacific CCO supported the networks in a yearlong process to develop logos and branding for each network. This process included brainstorming sessions across all sector workgroups and the steering committees in both counties. The ideas generated from the brainstorming sessions were submitted to a graphic designer employed by a network member organization who then created the logos for the networks. The graphic designer mocked up 9 logos for each network and member organizations ranked them and a logo was selected for each network. To view the logos for each network and their websites, please see below the URLs.

- www.resilientclatsopcounty.org
- www.columbiacountyctin.org

In supporting network member organizations during 2022, the following lessons were learned:

- Certain sectors workgroups like the criminal justice and business sectors can be established later once there are concrete activities for them to implement; remain flexible with how often workgroups meet, i.e., some sector workgroups can meet when the need arises, quarterly, etc.
- Given that TIC is an approach, it is important to distill it into actionable activities that people can implement; tools to systematically implement TIC into an organization help move this work forward.
- A TIC implementation tool and accompaniment process were designed in response to previous learning that folks were having a difficult time taking awareness of TIC and translating it into TIC implementation.
- Relevant population level data by county and sub-category is not always available; use OHA data or collect own data where necessary.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

Since the project inception, Columbia Pacific CCO facilitated a process in each county to support member organizations to design the networks including bringing together member organizations for collective impact visioning and designing network architecture. Network architecture in each county includes a charter, roles and responsibilities, trauma informed principles, vision, mission, and values. Each network created a design plan with action items in each of the following key areas: leadership and strategic planning, membership and citizenship, network activities, resources, and communication and knowledge circulation.

In 2023, Columbia Pacific CCO will continue to work across sectors with member organizations in Clatsop and Columbia counties to build a trauma informed network in each county. Sectors represented in each network include healthcare, education, child welfare, criminal justice, business, and community. Each network has a steering committee and six sector workgroups made up of local volunteers from member organizations or the community at large. Within the steering committee and the sector workgroups, member organizations work together to advance the initiatives in the strategic plan, reduce childhood trauma, heal ACEs, and build resilience in children and families. Member organizations commit to adopt trauma informed practices and to support each other on this journey. In 2023, with Columbia Pacific CCO support, the networks will roll out the TIC Implementation Tool to help member organizations assess TIC implementation in their respective organizations and apply to the Impact Fund.

The mission of the Clatsop County network is to "build capacity across sectors and within the community to adopt trauma informed practices, increase protective factors and prevent and heal childhood trauma in children, families and communities." The mission of the network in Columbia County is to "increase cross-sector collaboration, strengthen capacity of organizations and promote community awareness to prevent and heal childhood trauma and build resilience in children and families for a healthier Columbia County."

Columbia Pacific CCO has reached out to every culturally specific organization and all organizations that serve systemically underserved and vulnerable communities that we have been able to locate to date including LGBTQIA+ populations, people who have existing trauma, domestic violence survivors, black, indigenous, Latino and other populations of color, immigrants and/or refugees, people living on low incomes and those having less than a high school education. We are continuously seeking to reach out to underserved communities and will continue that outreach to determine if there are any culturally specific community organizations not yet involved in the networks. As studies show that vulnerable groups are more likely to report higher ACEs, the work for the networks – including raising awareness of ACEs and childhood trauma among service providers – inherently benefits these populations.

The target populations are children and their families in Clatsop and Columbia counties with a special focus on vulnerable and underserved populations who are more likely to bear the burden of higher ACEs.

This project is participatory and grew out of a community initiative based on a felt community need: leaders in Clatsop and Columbia counties contacted Columbia Pacific for support in developing trauma informed networks. Columbia Pacific CCO has supported leaders in Clatsop and Columbia counties to design and establish the trauma informed networks with the end goal being to embed them into each community. Current network initiatives were prioritized and developed in a participatory community strategic planning workshop and will be further developed together with partners in each sector workgroup. Efforts are collaborative across sectors as community organizations partner together towards a common goal.

F. Activities and monitoring for performance improvement:

Activity 1 description: Offer intermediate or advanced trauma informed care training across sectors with a special focus on member organizations and service providers who serve vulnerable populations in Clatsop and Columbia counites. To increase the total number of trainings offered during this initiative, the training will be held virtually as both counties can be reached with one training.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Trauma informed care training sessions

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Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2 trainings held	3 trainings held	01/2024	5 trainings held	01/2024
Monitoring measure 1.2	Intermediate/advanced trauma informed care training session completion			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Unknown	50 people trained in an intermediate TIC topic	01/2024	50 people trained in an intermediate TIC topic	01/2024

Activity 2 description: Offer network member organizations the opportunity and support to administer the TIC Implementation Tool in their respective organizations. The purpose of the TIC Implementation Tool is help member organizations systematically assess TIC implementation in their respective organizations. Once the organization has administered the tool, they can use the final scores to develop action plans with goals to work on the following year. Each member organization has three options to choose from for administering the tool: self-assessment, self-assessment & web staff survey and third-party assessment.

☒ Short term or ☐ Long term

Monitoring measure 2.1	TIC implementation tool agreement			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 agreement forms	Agreement forms from 10 organizations completed	01/2024	Agreement forms from 10 organizations completed	01/2024

Activity 3 description: Fund network member organizations from Clatsop and Columbia County to apply for grants from the Community Resilience and Trauma Informed Care Impact Fund. The Impact Fund is administered by the Oregon Community Foundation (OCF). Organizations will apply through the OCF portal. Columbia Pacific CCO will help each steering committee develop a review calendar to streamline the process. Columbia Pacific CCO will also share the application, timeline, and an FAQ with network member organizations prior to the application going live on the OCF website and provide support as needed.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Grant application support and funding			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 grants funded	2 organizations from Clatsop and Columbia County receive grants	01/2024	2 organizations from Clatsop and Columbia County receive grants	01/2024

Activity 4 description: Hire, directly supervise, train and onboard a Community Engagement Specialist I to support activities associated with the trauma informed networks, their strategic plans, and related strategies. The Community Engagement Specialist I will work to develop and implement strategies that will lead to long-term involvement of community institutions, organizations and individuals in the trauma informed networks. This Specialist will also work to support the development of a network in Tillamook County, replicating the process used in Clatsop and Columbia Counties.

☒ Short term or ☐ Long term

Monitoring measure 4.1	Staffing support			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 staff hired	1 Community Engagement Specialist I hired	01/2024	1 Community Engagement Specialist I hired	01/2024

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 419: RCT Psych Transitions Tracking

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

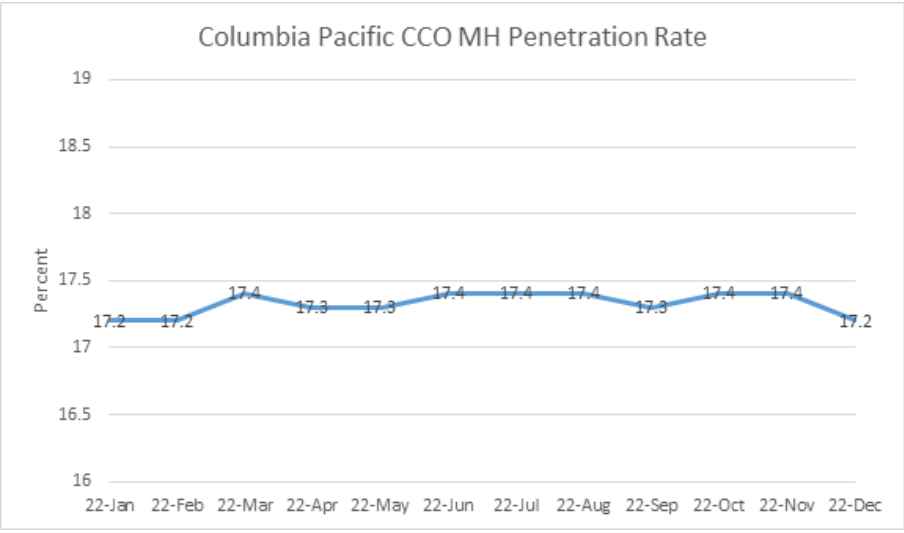
If continued, insert unique project ID from OHA: 419

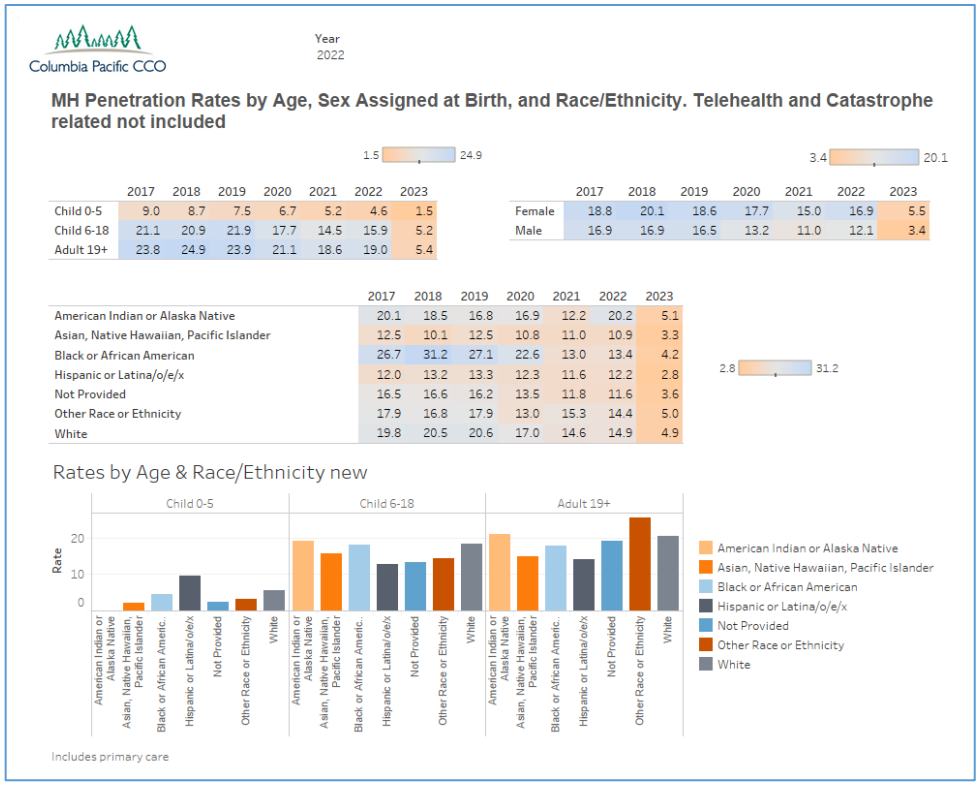
B. Components addressed

a. Component 1: Serious and persistent mental illness
b. Component 2 (if applicable): SHCN: Non-duals Medicaid
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting?
   ☐ Yes ☒ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Columbia Pacific CCO does not have any psychiatric hospital beds within our service region. Out of area hospitalizations increases the risk that members will not receive adequate supports as they return to their communities. This has been exacerbated by the stabilizing but still present behavioral health workforce shortage that has impacted our in-area behavioral health providers particularly hard. Self-report data from each county's Community Mental Health Provider (CMHP) indicates that while things are slowly improving, there still can be a waiting period (for some members) for appointments with individual therapists following discharge from acute care. Tracking of the overall MH penetration rates for 2022 shows that behavioral health utilization by our members remains low.





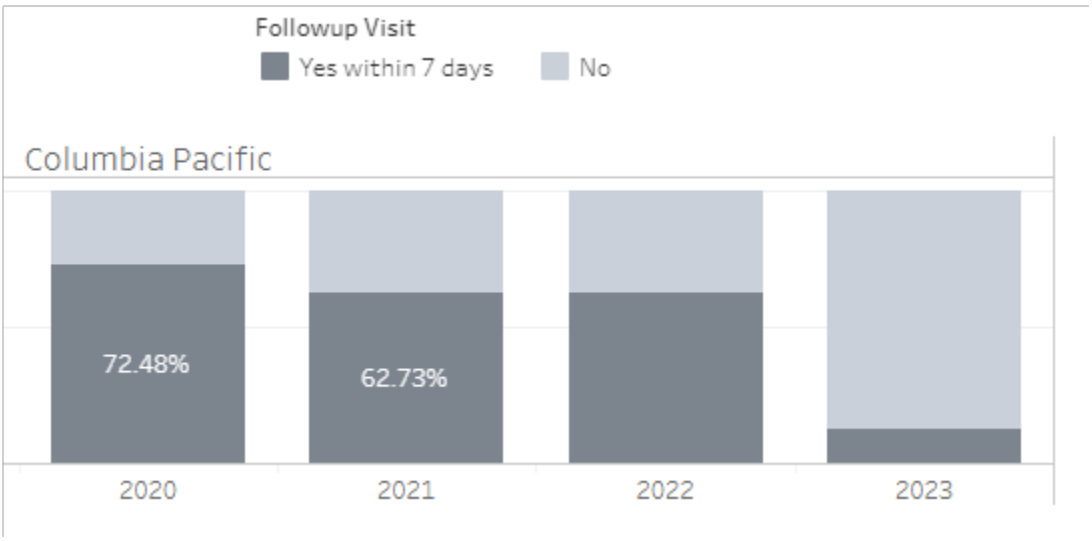
	2017	2018	2019	2020	2021	2022	2023
Child 0-5	9.0	8.7	7.5	6.7	5.2	4.6	1.5
Child 6-18	21.1	20.9	21.9	17.7	14.5	15.9	5.2
Adult 19+	23.8	24.9	23.9	21.1	18.6	19.0	5.4

	2017	2018	2019	2020	2021	2022	2023
Female	18.8	20.1	18.6	17.7	15.0	16.9	5.5
Male	16.9	16.9	16.5	13.2	11.0	12.1	3.4

	2017	2018	2019	2020	2021	2022	2023
American Indian or Alaska Native	20.1	18.5	16.8	16.9	12.2	20.2	5.1
Asian, Native Hawaiian, Pacific Islander	12.5	10.1	12.5	10.8	11.0	10.9	3.3
Black or African American	26.7	31.2	27.1	22.6	13.0	13.4	4.2
Hispanic or Latina/o/e/x	12.0	13.2	13.3	12.3	11.6	12.2	2.8
Not Provided	16.5	16.6	16.2	13.5	11.8	11.6	3.6
Other Race or Ethnicity	17.9	16.8	17.9	13.0	15.3	14.4	5.0
White	19.8	20.5	20.6	17.0	14.6	14.9	4.9

Timely access to follow up care after a psychiatric hospitalization, represented through the seven day follow up metric, for our most acute and vulnerable members living with Severe and Persistent Mental Illness (SPMI) and Special Health Care Needs (SHCN), remains a priority. We aimed to have our data team reconcile three data sources to create an accurate and reliable psychiatric transitions report for those members requiring a seven-day follow-up and coordination on discharge. An additional goal was to have organization specific dashboards that could be shared directly with providers to identify targeted areas for improvement.

While we were able to track total percent of inpatient admissions with a follow-up visit within seven days as demonstrated in the chart below, CareOregon has experienced delays in being able to reach our goal of having organization level data to share with our network partners. To quantify current access timelines and provide a general access picture, Columbia Pacific CCO used provider self-report data regarding access timelines as well as reports from our internal Intensive Care Coordination (ICC) team. This data, however, was not collected and recorded in an ongoing consistent or reliable way cross-regionally due to capacity limitations and competing priorities internally. Focus remains on building a cross-regional Behavioral Health Access and Capacity Dashboard.



2022= 62.18%

As a result, our cascading goals to stratify this data further by REAL-D and SOGI, and to identify opportunities for organization level PDSA processes to address barriers for each challenged site, have been delayed until 2023.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

The state quality measure of Follow-Up after Hospitalization for Mental Illness*, i.e., Seven Day Follow Up Metric*, provides one standard way of assessing the effectiveness of our current network and the ability to meet the needs of our most vulnerable populations. Additionally, we know that meeting this standard timeline reflects best practices in client care, improves health outcomes, and supports meaningful reductions in readmission rates. Members experiencing a readmission within 30 days is a key indicator that they are experiencing vulnerability and are at much greater risk for poor health outcomes.

At the onset of the previous measurement year our largest partner agencies noted access timelines of up to eight weeks from the time of first call to intake. The increase in wait times at our partner agencies had a direct impact on our Intensive Care Coordination (ICC) team and their ability to coordinate follow-up appointments for our members. We saw our overall seven day follow up stay static, hovering around 62% (see Section C for corresponding data). Knowing our partner agencies were experiencing ongoing workforce shortage issues, Columbia Pacific onboarded two new telehealth providers to expand the network of available providers with a goal of ensuring that we have a stable network that can withstand predictable and unpredictable variation in retention and capacity across the system and assure members will always have access to services.

Through 2022 CareOregon has been working to ensure that the Seven Day Follow-up Metric data set can be replicated internally in a consistent and reliable way. The addition of this metric to our Behavioral Health Access and Capacity dashboard was initially slated to be done in Q1 of 2023. Availability of this data via the dashboard has been delayed until Q2 of 2023 and thus remains a continued deliverable for 2023. This new dashboard will be paramount in our efforts to provide our network with consistent and reliable data to inform unique and specific short-term PDSA processes to address barriers. Once a benchmark is established, we will subsequently increase the target by 10% or more with cycles of monthly progress reports.

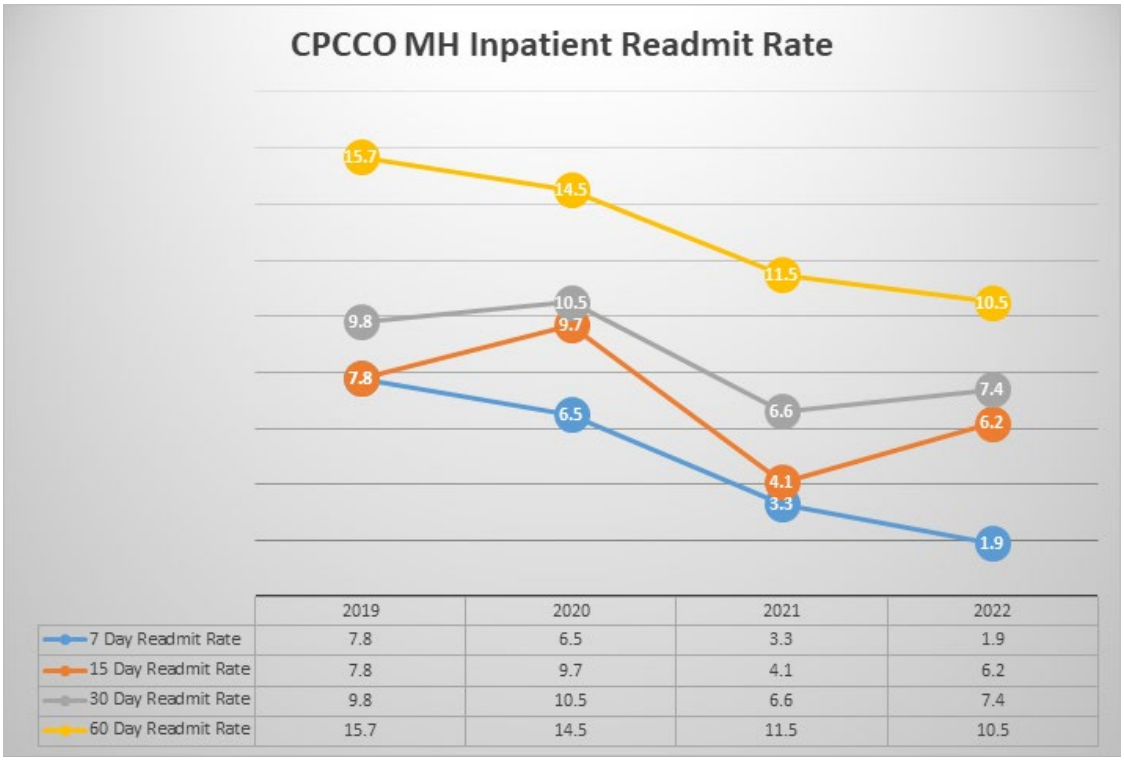
Currently any Columbia Pacific CCO member who is admitted to inpatient acute care is automatically screened by one of our Intensive Case Coordinators on the Regional Care Team (RCT). The RCT helps connect Members to the most appropriate outpatient supports and ensures that members receive a follow up appointment with a new or established behavior health provider. The ICC team has difficulty connecting members to care in a timely way, resulting in reoccurrence of ED utilization and exacerbation of presenting problems. Additionally, access contractions have led to longer service periods for ICC coordination, and a decline in the number of members that have access to this level of service intensity. Accurately understanding caseload sizes and timelines trends would allow us to better understand how our care coordination resource is being utilized, the community's need for intensive levels of support and allow us to assess staffing and resources needs on the care coordination team. Due to competing data needs of the organization a dashboard indicating timeline trends for care coordination was not a feasible build.

E. Brief narrative description: Brief, high-level description of the intervention that addresses each component attached and defines the population.

In 2023 Columbia Pacific CCO plans to actualize the ability to consistently and reliably produce the seven day follow up metric data within an Access and Capacity Dashboard. Additionally, we are working toward an ability to stratify this data by REAL D and SOGI, rather than only by race. Our goal date for these initiatives has moved to July 2023. At that time CPCCO will continue with the previously laid out Objective 1.1 and identify organization specific baseline measurement to be shared with our network partners and then inform PDSA workflow improvement opportunities. Workflow improvement will build upon our existing care coordination efforts for this population. When members are connected to timely care within the behavioral health setting, they are more effectively able to have their health needs met.

Additionally, we know that meeting this standard timeline reflects best practices in client care, improves health outcomes, and supports meaningful reductions in readmission rates. Members experiencing a readmission within 30 days is a key indicator that they are experiencing vulnerability and are at much greater risk for poor health outcomes.

Transitional care is a core function within our care coordination services. Hospital discharge is a complex process representing a time of significant vulnerability for members. Due to this, transitions support is currently provided to all members experiencing psychiatric hospitalization. This work reflects best practice in member care, improves health outcomes and supports meaningful reductions in readmission rates. Currently members who are admitted to inpatient acute care are screened by one of our intensive care coordination (ICC) team members. ICCs help connect members to the most appropriate care coordination team and ensure that members receive a follow up appointment with a new or established behavioral healthcare provider.



Over the past few years, we have seen a reduction in readmission rates overall; however, just in the past year we have seen the 15 day readmit rate 30 day rate increase. Transition interventions used throughout the care coordination process include understanding the cause of the readmission and providing member-specific education about red flags, which are explained as warning signs or symptoms that indicate the member's condition is worsening and could result in ad ED visits or hospital readmission. The population of focus is members with an inpatient admission with mental health diagnosis.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Reconcile data from three unique sources to ensure consistency and reliability of 7-day follow-up reporting and analysis.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Single, internal data source for 7-day follow-up rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Site-specific data tracking of seven day follow up is not available, outside of agency self-report	7-day follow-up rates produced consistently from internal data	06/2023	Improvement target set based on single, internal data source	08/2023

Activity 2 description: Ensure seven day follow up can be stratified by REALD and SOGI to review for equity implications. Completion of initial analysis to identify any current trends in impacts based on REALD.

☒ Short term or ☐ Long term

Monitoring measure 2.1	7-day follow-up metric stratification			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
7-day follow-up metric is not stratified by race, ethnicity, language	Ability to stratify 7 day follow up data by REALD	08/2023	Analysis of stratified data conducted	09/2023

Activity 3 description: Incorporate more reliable and actionable data source into RCT care coordination workflow.

☐ Short term or ☒ Long term

Monitoring measure 3.1	30-day MH re-admission rate			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
7.4%	7.0%	01/2024	6.5%	01/2025

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

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

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

If continued, insert unique project ID from OHA: Add text here

B. Components addressed

a. Component 1: SHCN: Full benefit dual eligible
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☐ Yes ☒ No

C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

The CareOregon Advantage D-SNP plan consists of full duals, with **98%** being CareOregon CCO duals, meaning CareOregon manages both the Medicaid and Medicare benefits on behalf of Columbia Pacific CCO. The gaps in care coordination between benefits are greatly reduced for these members. Our teams work across both benefit types and are highly skilled in navigating the coordination of services and benefits for the membership.

In the rare circumstance a member has CareOregon Advantage but does not have CareOregon Medicaid, the Medicaid Management Information System (MMIS) is used to determine the Medicaid health plan. Care Coordination staff connect to the member's Medicaid health plan when it is determined to be other than CareOregon to coordinate services for dual members. These services can include access to Health-Related Service Funds HRS-F), behavioral health, and Nonemergent Transportation (NEMT) resources through their Medicaid benefit. The cross-plan care coordination is accomplished telephonically or through secure email. Our Regional Care Team care coordinator holds an Interdisciplinary Care Team (ICT) conference to coordinate services in some highly complex cases.

Our D-SNP population, the population of focus, includes members with a high prevalence of underlying medical, social, cognitive, and environmental factors that affect their overall health status.

These factors include members living in institutional settings and/or with:

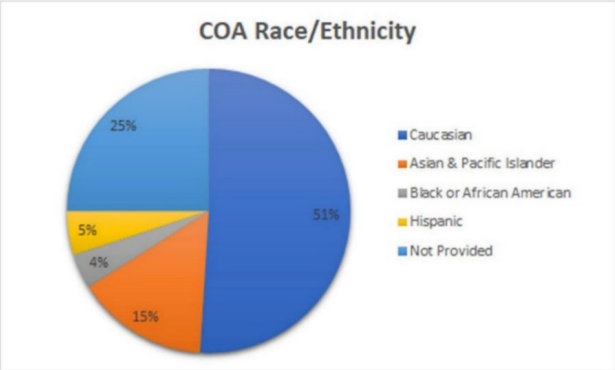
- Low income
- Low educational status
- Disability status
- Mental illness, including SPMI (serious and persistent mental illness)
- Substance use disorder issues
- Supportive services

Age

The top three age distribution categories are 65-74 (36%), 75-89 (23%), and 55-64 (18%), as seen in the table to the right.

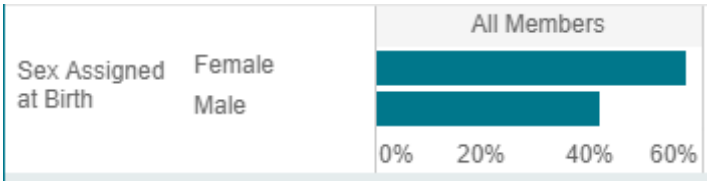
Age	Percentage of Population
90+	2%
75-89	**23%**
65-74	**36%**
55-64	**18%**
45-54	9%
35-44	7%
25-34	5%
19-25	1%

Race and Ethnicity



Gender

Gender distribution is predominantly female (58%) compared to males (42%).



D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

While all CareOregon Advantage members could be considered as having special health care needs, we have chosen to focus this project on improving health outcomes for our "most vulnerable" members within our D-SNP population.

CareOregon Advantage defines vulnerability as a state of increased need, often imposed on members by circumstances outside their direct control. It places them at increased risk of ineffective medical treatment and/or poor health outcomes. This state of member vulnerability requires additional health plan resources and focused support as we work to achieve CareOregon Advantage's mission of making health care work for everyone.

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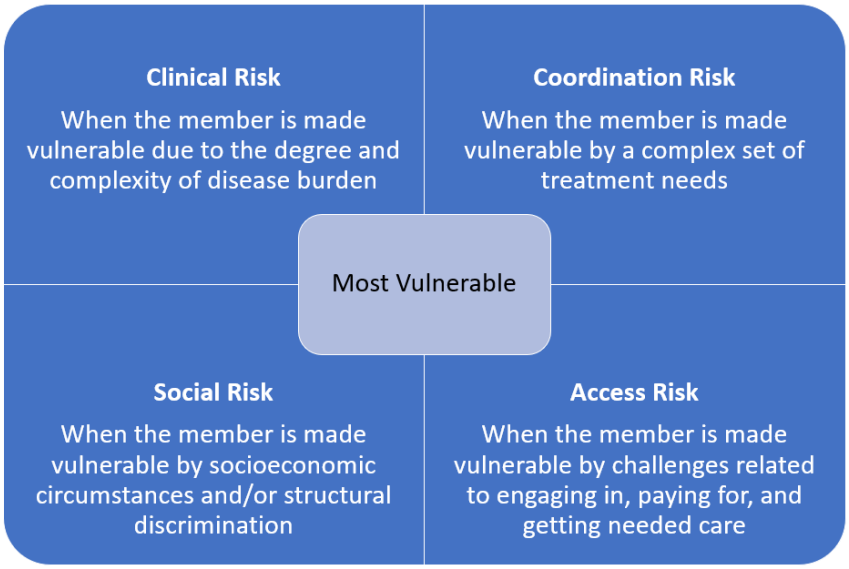
The goals of our vulnerability framework are:

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

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



The data definitions for the algorithm that drives these risk categories can be seen below.

Risk Type	Methodology Used

Clinical Risk	• Any 30-day readmission in the last year OR any of the following:
	• Two hospitalizations during the previous 12 months
	• SPMI or SUD and a high risk of future inpatient needs in the next six months utilizing Johns Hopkins ACG.
	• Three or more of the following chronic conditions
	  ○ Cancer
	  ○ Cerebrovascular disease
	  ○ Chronic kidney disease
	  ○ Chronic obstructive pulmonary disease
	  ○ Chronic liver disease
	  ○ Diabetes
	  ○ Congestive heart failure
	  ○ Persistent asthma
	  ○ Depression
	  ○ Schizophrenia
	  ○ HIV
	  ○ Ischemic Heart Disease

	• OR identified through clinical judgment of Medical Directors or medical provider as needing a higher level of care management
Access Risk	• No provider visits in the last twelve months OR • Johns Hopkins ACG flag for frailty*, cognitive decline, assistive device or paralysis related to diagnosis or DME claim OR • More than five ED visits in the last 12 months that resulted in discharge home OR • Health Risk Assessment Tool (HRAT) indication that member has difficulty taking medications or has no support to overcome ADL barriers
Coordination Risk	• Drug Therapy Coordination Risk (DTCR)** flag of yes and a polypharmacy flag of yes in the measurement period • Clinical complexity that indicates the need for care coordination between specialist-driven care and drug therapy coordination risk defined above
Social Risk	• BIPOC race or ethnicity OR • Primary language other than English OR • Age greater than 85 OR • HRAT indications of housing instability or food insecurity

We define the sickest and most vulnerable D-SNP members as those who have clinical risk accompanied with one additional risk (social, coordination or access). These most vulnerable members represent about 21% of the overall D-SNP population.

Gender

Enrollment Gender Identification	# of Members	% of total Vulnerable Cohort	Comparative % among all DSNP members
Male	69	40%	39.5%
Female	103	60%	60.5%

The most vulnerable cohort has a higher incidence of members identifying as female than the overall D-SNP population. We believe this coincides with the incidence of average age and the knowledge that women tend to outlive their male counterparts.

Impactful clinical initiatives focusing on women's health issues can include:

- Extra attention on female heart health
- Hormone replacement therapy risk and benefits analysis
- Osteoporosis screenings
- Mammograms (when indicated)

The Intensive Care Coordinator working with the vulnerable cohort can assess these unique population characteristics. Assessment templates within the care management platform contain specific questions for women's health and are part of the Rapid Access Care Plan when appropriate, described in section E.

Race and Ethnicity

Race or Ethnicity Marker	# of Members	% of total Vulnerable Cohort	Comparative % among all DSNP members
American Indian or Alaska Native	4	2.3%	1.0%

Race or Ethnicity Marker	# of Members	% of total Vulnerable Cohort	Comparative % among all DSNP members
Asian or Pacific Islander	2	1.2%	0.8%
Black or African American	2	1.2%	0.5%
Hispanic (of any race)	7	4.1%	1.7%
White	34	19.8%	19.7%
No race or ethnicity information provided	113	65.7%	66.7%

Most categories in the Race and Ethnicity table above are similar to the overall D-SNP population. We have a slightly higher representation for those members who identify as White. We see a decrease in members who identify as Asian and Pacific Islander.

Language

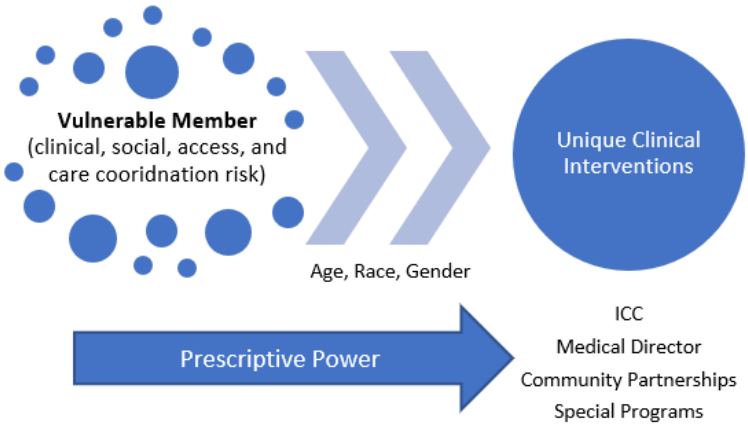
Primary Language	# of Members	% of total Vulnerable Cohort	Comparative % among all DSNP members
Chinese	1	0.6%	0.1%
English	160	93.0%	96.8%
Russian	0	0%	0%
Spanish	2	1.2%	0.8%
Vietnamese	0	0%	0%

Other than English, most languages spoken in the vulnerable cohort are less prevalent in the general population. Understanding the languages spoken in this cohort allows us to tailor services to those members. We know that receiving health services in one's preferred language is paramount to optimal health outcomes and experience. We have determined a gap in adequate interpretation services and correctly translated member/patient materials within our network's health system.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

The illustration below combines the risk types in a visual demonstrating the relationship between the most vulnerable members, their demographics and anticipated unique clinical interventions.

Our definition of the most vulnerable member starts with clinical risk. Briefly, clinical risk is when the member is made vulnerable due to the degree and complexity of disease burden. Clinical risk includes specific diagnoses, hospital utilization and clinical judgment.



To meet the needs of our most vulnerable population we have designed special services, staff training, and care planning activities.

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

The special training covers:

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

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

Through the prescriptive power of our algorithm, we know there are critical elements of care to be considered for this vulnerable population, such as clinical, access, social and care coordination risk. We also know that immediate and proactive access to care and services is paramount to supporting this population. We utilize the prescriptive power within our vulnerability algorithm to develop targeted interventions. The **Rapid Access Care Plan** is a critical component of the intervention. The specialized care plan template uses questions designed with this population to guide the ICC in creating a proactive set of interventions. Examples of these interventions are in the table below. The purpose is to pre-plan what the member is likely to need based on their medical, behavioral, or social presentation.

While the ICC will also address current issues, they are trained to work with the ICT to predict the member's needs in the next three to six months. This includes but is not limited to specialist referrals, medical equipment, prior authorizations, social health needs or specialized services that fall outside the normal process. The ICC uses the Rapid Access Care Plan (see template below) to proactively submit referrals, match specialty services, or gain authorizations before they become acutely needed. The Rapid Access Care Plan is reviewed every 90 days, or sooner, depending on the needs of each member.

Risk Type	Services
Clinical Risk + Access Risk	• Signify in-home assessment • Papa Pals- social support • Traditional Health Worker • Possible referral to in-home primary care options

Clinical risk + Social Risk	• Unite Us referrals for social needs
	• Health-Related Service Flex Funds (Medicaid benefit)
	• Social Connection
	  ○ Papa Pals
	• Food Insecurity
	  ○ Food Delivery
	  ○ CSA/ Produce Rx
	  ○ Food Literacy

Clinical + Coordination Risk	• Referral to Pharmacy Team • Transgender Health Care Coordinator • Respiratory Therapist • Healthwise- Health Education • Community Paramedicine • COPD Program

The visual below outlines the key elements of the program.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Development of the Rapid Access Care Plan for each member identified.

☒ Short term or ☐ Long term

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Monitoring measure 1.1	Percent of identified members who have a Rapid Access Care Plan (RACP) developed in 2023			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Rapid Access Care Plans to be created for this population	50% of identified members have a rapid access care plan created	07/2023	100% of identified members have a rapid access care plan created	12/2023
Monitoring measure 1.2	Percent of members' Rapid Access Care Plans have been actively updated			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current baseline – Report to be built	25% of members with a Rapid Access Care Plan have been actively updated by their assigned care coordinator	07/2023	50% of members with a Rapid Access Care Plan have been actively updated by their assigned care coordinator	12/2023

Activity 2 description: Engagement in appropriate services identified as part of their Rapid Access Care Plan (RACP)

☒ Short term or ☐ Long term

Monitoring measure 2.1	Percent of members with social risk who receive an accompanied service (Unite Us referral, connection to Papa Pals, or food services through Mom's Meals or member OTC card).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current baseline – Report to be built	30% of members with access or social risk receive a targeted service/intervention from their RACP	07/2023	60% of members with access or social risk receive a targeted service/intervention from their RACP	12/2023

Monitoring measure 2.2	Member engagement with PCP or other specialty services			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current baseline – Report to be built	50% of members identified will have a PCP or Specialty Care visit	07/2023	80% of members with access or social risk receive a targeted service/intervention from their RACP	12/2023

Activity 3 description: Improve health outcomes of the most vulnerable population

☐ Short term or ☒ Long term

Monitoring measure 3.1	**Medication adherence for improved disease management**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No current baseline – Report to be built	2% improvement over previous year adherence measure for: • RASA • Statins • Diabetes	12/31/23	2% improvement over previous year adherence measure for: • RASA • Statins • Diabetes	12/31/24
Monitoring measure 3.2	**Avoidable ED Visits**			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Reducing avoidable ED visits	2% lower than expected for avoidable complaints	12/31/23	5% lower than expected for avoidable complaints	12/31/24

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: Project 420: Pediatric Asthma

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

If continued, insert unique project ID from OHA: 420

B. Components addressed

a. Component 1: Utilization review
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

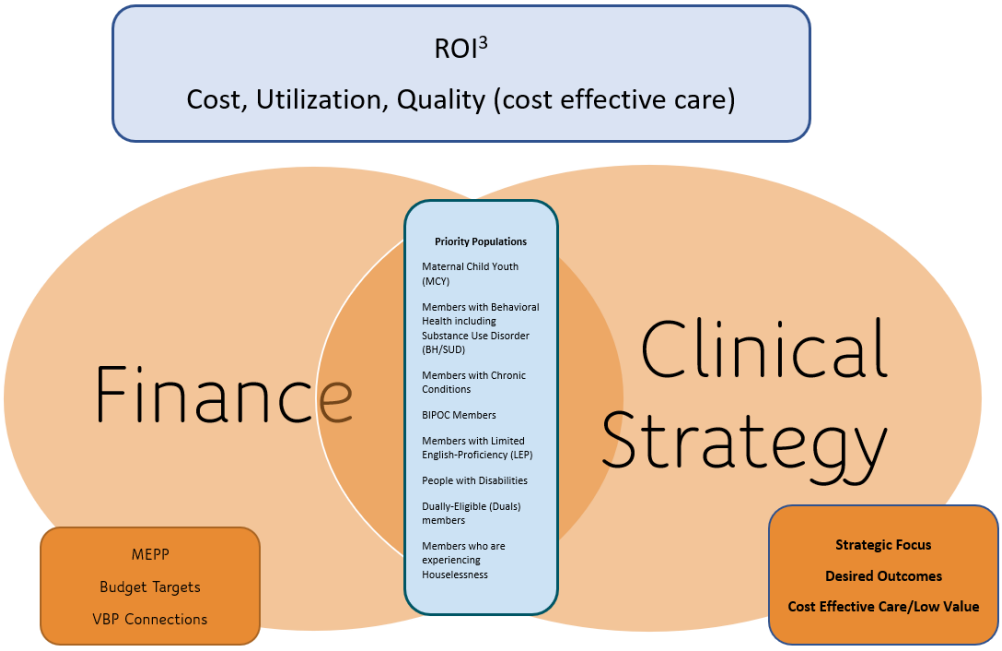
C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Utilization Program Overview

Per TQS guidance, this section contains a brief overview of CPCCO's utilization review process. Information specific to the proposed project is contained in the following section.

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives, including those employed by CPCCO. While there are many forums where cost and utilization trends are reviewed, the group is accountable for ensuring that overall cost and utilization goals tied to health outcome optimization are met. Under the COQHO functional committee, the Return on Investment for cost, utilization, and quality (ROI3) workgroup provides clinical strategy recommendations for improved health outcomes. The committee focuses on:

- Prioritizing cost-effective care and over/under utilization problem areas for focused attention;
- Developing strategies to address cost, under/over utilization, and population health outcomes; and
- Optimizing utilization for CPCCO's priority populations.



This group, along with the Medical Management department, monitors and analyzes utilization trends and clinical variation, for physical, behavioral, and oral health, on an ongoing basis in order to identify potential or actual incidents and/or patterns of over/under utilization. Individual projects, such as the one described here, are initiated from this data review.

Below is an example of a cost and utilization dashboard used for this purpose. Additional views allow the user to drill down into more specific service categories, including utilization by procedure groups, procedure codes, and facilities. Individual service and/or project dashboards, as provided in the subsequent section, have incorporated REALD data in order to identify opportunities to close disparities in care. Additional examples can be provided upon request.

If trends/patterns are recognized, necessary steps are taken to investigate and address these variances. Thresholds are established using external nationally recognized sources whenever possible. Data originates from multiple sources within the organization, such as Health Services Operations, Pharmacy, Claims, Appeals and Grievances, Quality Assurance, Clinical Quality Improvement, and Business and Population Health Analytics. Data sources may include, but are not limited to, Pharmacy Benefits Manager (PBM) claims and reporting platforms, QNXT, SAS BI and GSI, our care coordination platform. If the possibility of over/under utilization is identified, a qualitative analysis is conducted to identify reasons for the variance and potential solutions.

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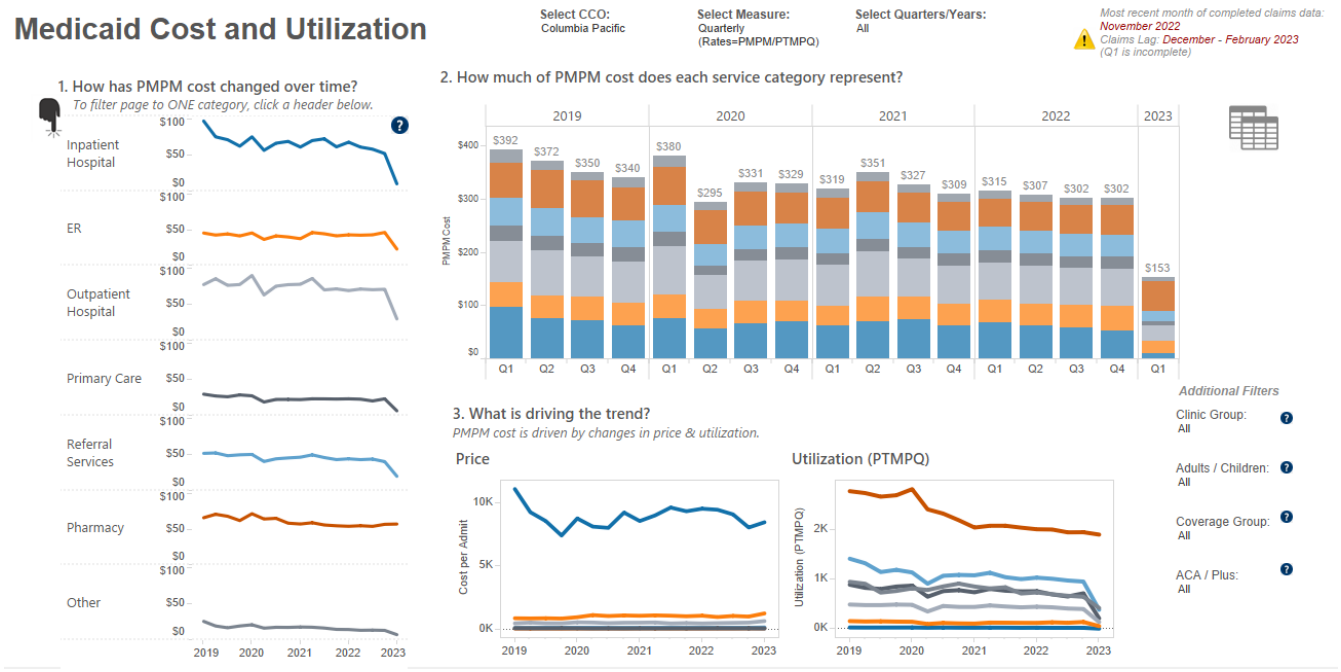

Individual cases may also be flagged for review by our Medical Management team and are subsequently reviewed by our team of Medical Directors and/or through our Peer Review committee, depending on the case.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

According to a recent study conducted by the Agency For Healthcare Research and Quality (AHRQ), asthma affects approximately 1 in 12 children in the United States (Akinbami, 2016). It is associated with increased hospitalizations and emergency department (ED) visits, as well as racial and ethnic disparities in outcomes (Cabana et al, 2006). Many factors can lead to a child with asthma receiving care in the ED such as air pollution, poor asthma control, severity of symptoms, decreased access to care, and ability to enact emergency care (such as use of a rescue inhaler) among many others. A significant proportion of asthma hospitalizations can be avoided with appropriate primary care asthma management (Homer, 1996).

In a study published in the American Academy of Pediatrics (volume 122, Issue 4 October 2008) by Smith, et. al., it was concluded that of the children included in the study, 37% of the total group had suboptimal asthma control. This was found to be more common in Hispanic children (51%) than in Black (37%) or white (32%) children. Specific to Columbia Pacific CCO, our data indicates an opportunity to prioritize efforts towards Native American, BIPOC, and Latinx members.

Controller medication underuse was present for 133 children (48% of those with suboptimal asthma control and 18% overall). Controller medication underuse was more common among Hispanic (44%) and Black (34%) children than white (22%) children.

Between 2020 and 2022 we have seen disparities increase for pediatric members with asthma who seek care in acute settings (i.e., Inpatient admits, Emergency Department visits, and urgent care visits). This disparity is particularly pronounced among American Indian/Alaskan Native & Hispanic pediatric members with asthma.

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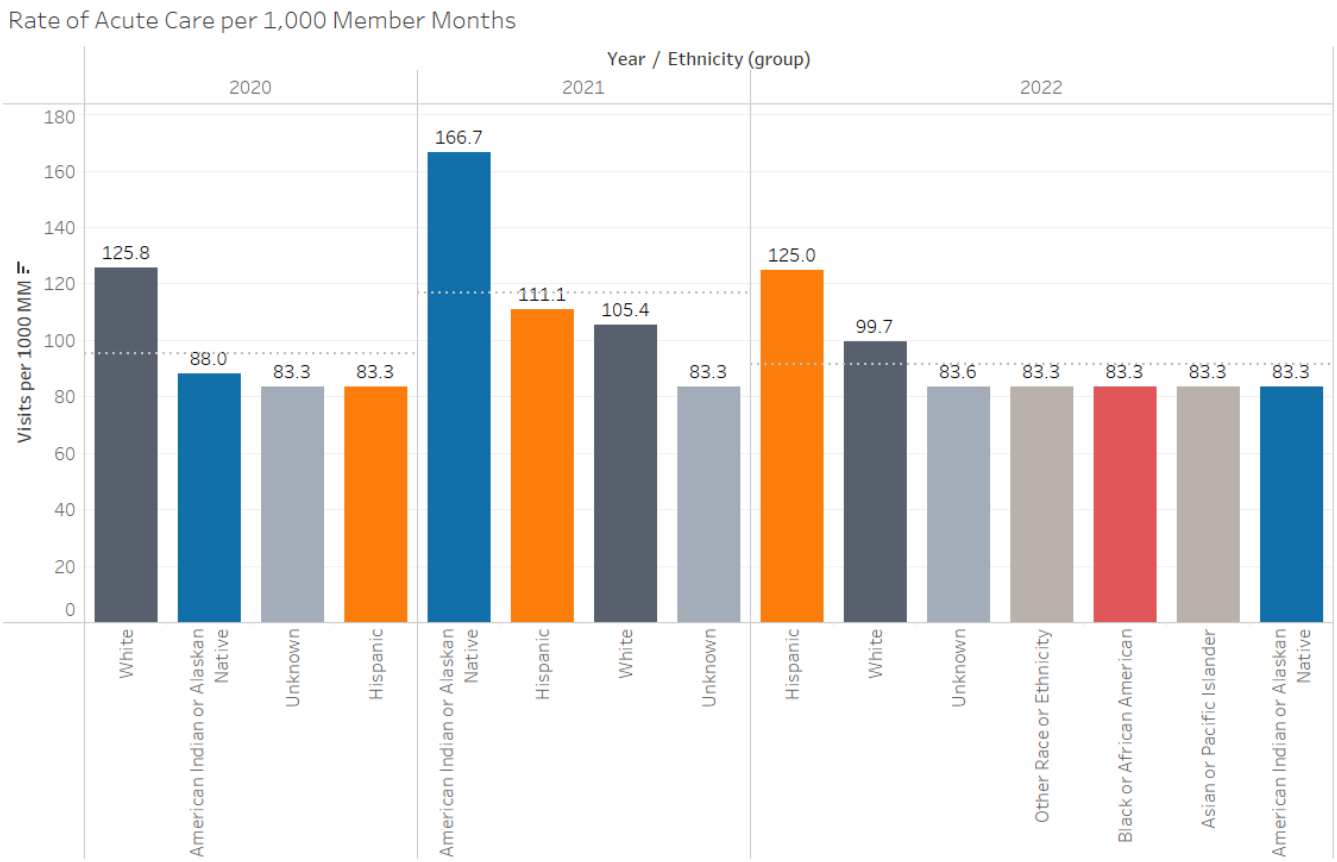

Columbia Pacific launched our planned intervention (described in the subsequent section) as of July 2022, quickly altered workflows as needed, and delivered on the core of the planned intervention for the last 6 months of 2022 and to present day.

According to the latest available 2019-2021 Optumas MEPP dashboard data, asthma is no longer among the top 5 highest cost Episodes for CPCCO. However, CPCCO has chosen to continue its focus on preventing avoidable acute care visits as a result of pediatric asthma exacerbation as this aligns with our long-term strategic goals, the potential for upstream impact, and the population is actionable. For those reasons and the resources committed to this project, we have chosen not to pivot at this time.

During the specified time range, data from this dashboard shows a 23% avoidable AAE percent totaling $2,142,385 of AAE cost out of the total Asthma episode cost of $9,184,770 in our region. See below:

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Episode Subtype: **Asthma.** **AAE %: 23%** **AAE Cost: $2,142,385** **Total Episode Cost: $9,184,770**

While we have been using the Optumas data supplied by the OHA at an aggregate level to identify opportunities within AAE, we have struggled to make the member-level data actionable since it is not currently tied to other data sources in our Enterprise Data Warehouse (EDW). Given that, we are unable to group members using this dataset in ways that are aligned with other analyses and programs. In addition, we currently find the greatest value in using member-level data to drive actionable outreach. The member-level data supplied in Optumas is not as current as data we have accessible internally. Therefore, we have been able to do more meaningful, robust analysis using our own member-level data to drive strategy implementation.

From November 1st, 2021 to November 30th, 2022, 762 members ages 0 – 17 had a diagnosis of asthma. Of that group, 329 members had an ED visit or inpatient admission (for any cause).

In 2022 Columbia Pacific CCO developed a dashboard for tracking the intervention implemented this year and found a total of 20 pediatric members and their families were served. Of that total group, 16 received a pharmacist assessment, 1 received a pulmonary assessment, and 16 members had a medication review or medication reconciliation as part of the intervention. Given that our initial intervention cohort was 20 members and more than 50% of the cohort received a medication review, our 2022 target was met.

A pharmacist receives the Collective Medical report weekly of asthma-induced ED or IP pediatric hospitalizations and proceeds to then review the patient's medications, fill history, service utilization and other relevant health factors that inform next steps. The pediatric member is then referred to a CareOregon Respiratory Therapist (RT) to complete a full assessment and outreach to the patient to identify any additional related needs. The patient's primary care provider and other prescribers are contacted to inform them of the identified recommendations or concerns. If the patient would benefit from an in-home assessment, they are then referred to a Community Action Team's (CAT) Healthy Homes program which outreaches to the family to offer that support.

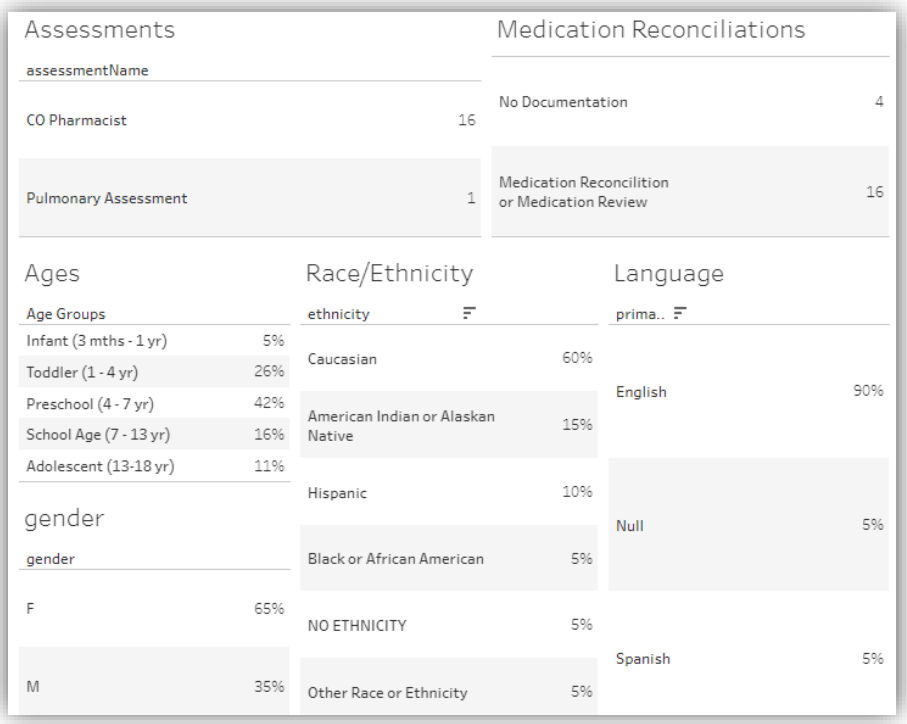
In 2022 Columbia Pacific CCO worked with CAT Healthy Homes to ensure this home-based support, designed to identify any risks, concerns, or needs, is available to offer to family's home repair and environmental mitigation as needed. Though no members received a CAT Healthy Homes home-visit this year due this offering only being available in a third of our region (Columbia County) and the resource and referral pathways continue to be socialized with the Regional Care Team.

Other programmatic factors contributing to low numbers of member reach:

- Low RCT Pharmacist Capacity
- Workflow/program refinement
- Volume of cases was low
- Number of members RCT was able to reach/engage
- Geographic area of complex members combined with resources available- the most complex members were in Tillamook County which does not have any community resources for home visiting.

Of the 20 pediatric members who received an intervention in 2022:

- 5% were infants aged 3 mos-1 year old
- 26% were toddlers aged 1-4 years old
- 42% were preschool aged children between 4-7 years old
- 16% were school aged children between 7-13 years old
- 11% were adolescents between 13-18 years old
- 35% of these pediatric members were male identifying while 65% were female identifying
- 60% identified as Caucasian
- 5% had no identified ethnicity on file
- 10% were Hispanic
- 5% were of other race or Ethnicity
- 15% were American Indian or Alaskan Native
- 96% of these members spoke English as their primary language
- 2% identified Spanish as their primary language
- 2% had undetermined primary language



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Our primary goals for 2022 were to get the infrastructure in place to actively track this cohort and implement the intervention, both of which were accomplished. We will not know until the intervention is in place longer if it is having the desired impact on utilization.

Given that this is a continuation of last year's project, we anticipate approximately the same savings as previously reported.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

A weekly Collective report of pediatric members aged 3 months to 18 years with asthma is run to identify pediatric members who had an ED visit or Inpatient (IP) admission in the prior week. The cases are then reviewed by our Regional Care Team (RCT), which includes a clinical pharmacist, to determine if the admission was related to their asthma diagnosis. For those whom it was determined asthma was a factor in their ED visit or IP admission, a case review follows to assess potential drivers of their utilization and referrals to resources are made as appropriate. Inhaler usage, spacer usage if applicable, and proper inhaler technique is reviewed. A written guideline of parameters for future use of ED is formulated and provided to patient/family/caregiver. An outreach call script is used by all care team staff outreaching members to ensure standardization. The timeliness of the call is another standardized component of this model which stipulates that within a week of the asthma-induced ED or IP admission outreach support is offered.

The role of the CareOregon Respiratory Therapist (RT) is to conduct telephonic outreach to the family to complete their full assessment and communicate any concerns and findings to the members provider for follow up. If appropriate, an asthma assessment is sent to the pediatrician and/or pulmonologist serving that member. The RT also identifies if the family would benefit from a referral to the home assessment program offered by CAT Healthy Homes.

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

Performance Measurement Strategy

Definitions for quantitative performance measures are given below.

Monitoring Measure 1.2

- Numerator definition: Members 2 - 18years of age with an acute care visit related to asthma exacerbation
- Denominator definition: Members 2 - 18years of age with a diagnosis of asthma
- Measurement period (benchmark): January 1, 2023 – December 31, 2023
- Baseline period and population: Members 2 – 18 years of age with an acute care visit related to asthma exacerbation (January 1, 2022 – December 31, 2022)

Monitoring Measure 1.3

- Numerator definition: TBD
- Denominator definition: TBD
- Measurement period (benchmark): January 1, 2024 – December 31, 2024
- Baseline period and population (benchmark): TBD (January 1, 2023 – December 31, 2023)

Monitoring Measure 2.3

- Numerator definition: Members 2 - 18years of age with an acute care visit related to asthma exacerbation that received outreach from a respiratory therapist
- Denominator definition: Members 2 - 18years of age with an acute care visit related to asthma exacerbation
- Measurement period (target): January 1, 2023 – December 31, 2023
- Baseline period and population: TBD (January 1, 2022 – December 31, 2022)

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

Develop a weekly action report which lists all members with pediatric asthma with an ED or hospital admit. Monitor acute care utilization for population overall and among REALD subpopulations. Provide outreach to eligible population by respiratory therapist. Assess acute care utilization for asthma-related pediatric concerns by REALD and identify opportunities for reducing disparities.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Pre-post hospital Utilization report			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No tracking of pediatric asthma cohort in place.	Report built within Collective Medical listing all pediatric members with Asthma admitted to ED or hospital with an asthma related diagnosis	06/2022	Report built within Collective Medical listing all pediatric members with Asthma admitted to ED or hospital with an asthma related diagnosis	06/2022
Monitoring measure 1.2	Proportion (%) of care for asthma occurring in acute care settings (ER, IP, Urgent Care)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12.3%	10.3%	07/2023	10.3%	12/2023
Monitoring measure 1.3	Proportion (%) of care for asthma occurring in acute care settings (ER, IP, Urgent Care)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Target for disparity reduction unknown	Target set for reducing disparities in asthma-related care	07/2023	Meet target for reducing disparities in care	12/2024

Activity 2 description: Provide outreach to eligible population by respiratory therapist. Develop asthma-related acute care report for intervention cohort. Subsequent asthma-related acute care visits 12 months post intervention will be monitored quarterly with outreach to provider and/or member/family to identify opportunities for most effectively supporting the family to reduce future events. Culturally and/or linguistically specific interventions will be developed to address member needs if disparities identified and intervention not impacting acute care rates.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Asthma-related acute care rates among intervention cohort report			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Intervention cohort re-admission report unavailable	Intervention re-admission report built	06/2023	Intervention re-admission report built	06/2023
Monitoring measure 2.2	Asthma-related acute care rates among intervention cohort			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Acute care rates post-intervention unknown	Acute care rates post-intervention known	06/2023	No difference in acute care rates post-intervention by REALD	12/2024
Monitoring measure 2.3	Percent of members in intervention cohort receiving outreach from respiratory therapist			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Unknown	50%	12/2023	75%	12/2024

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: MEPP 2: Diabetes management

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

If continued, insert unique project ID from OHA: MEPP #2 (New to TQS, continued from MEPP)

B. Components addressed

a. Component 1: Utilization review
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
g. If this is a utilization review project, is it also intended to count for MEPP reporting? ☒ Yes ☐ No

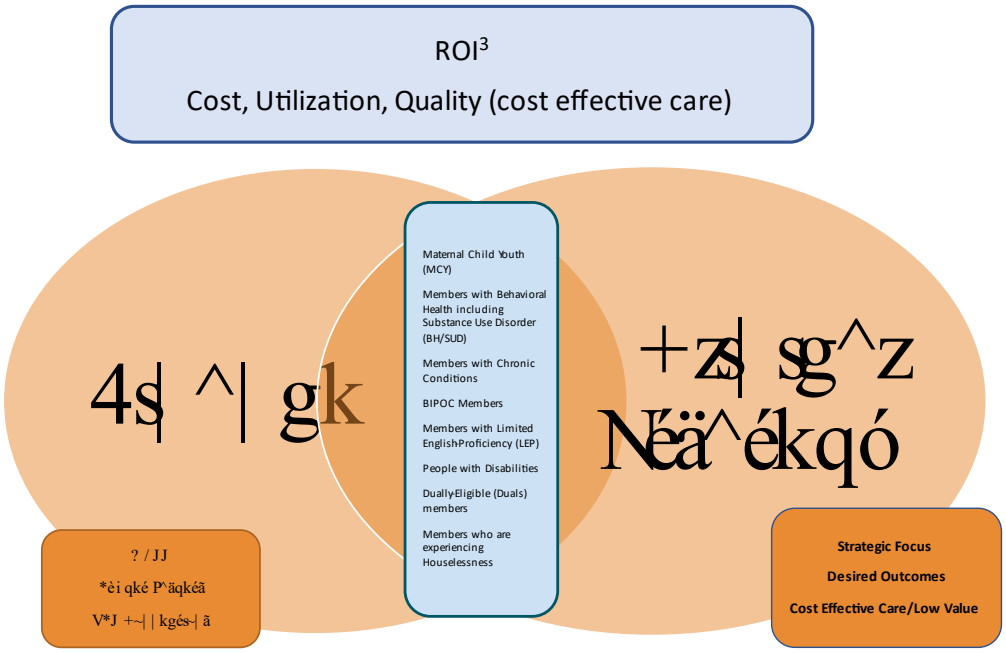
C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

Utilization Program Overview

Per TQS guidance, this section contains a brief overview of CPCCO's utilization review process. Information specific to the proposed project is contained in the following section.

The CareOregon Quality and Health Outcomes Steering Committee (COQHO) guides the enterprise-wide quality and health outcomes structure and population health framework that determines cross-departmental, cross regional and benefit-related clinical quality improvement strategies and initiatives, including those employed by CPCCO. While there are many forums where cost and utilization trends are reviewed, the group is accountable for ensuring that overall cost and utilization goals tied to health outcome optimization are met. Under the COQHO functional committee, the Return on Investment for cost, utilization, and quality (ROI3) workgroup provides clinical strategy recommendations for improved health outcomes. The committee focuses on:

- Prioritizing cost effective care and over/under utilization problem areas for focused attention;
- Developing strategies to address cost, under/over utilization, and population health outcomes; and
- Optimizing utilization for CPCCO's priority populations.



This group, along with the Medical Management department, monitors and analyzes utilization trends and clinical variation, for physical, behavioral, and dental health, on an ongoing basis in order to identify potential or actual incidents and/or patterns of over/under utilization. Individual projects, such as the one described here, are initiated from this data review.

Below is an example of a cost and utilization dashboard used for this purpose. Additional views allow the user to drill down into more specific service categories, including utilization by procedure groups, procedure codes, and facilities. Individual service and/or project dashboards, as provided in the subsequent section, have incorporated REALD data in order to identify opportunities to close disparities in care. Additional examples can be provided upon request.

If trends/patterns are recognized necessary steps are taken to investigate and address these variances. Thresholds are established using external nationally recognized sources whenever possible. Data originates from multiple sources within the organization, such as Health Services Operations, Pharmacy, Claims, Appeals and Grievances, Quality Assurance, Clinical Quality Improvement, and Business and Population Health Analytics. Data sources may include, but are not limited to, Pharmacy Benefits Manager (PBM) claims and reporting platforms, QNXT, SAS BI and GSI, our care coordination platform. If the possibility of over/under utilization is identified, a qualitative analysis will be conducted to identify reasons for the variance and potential solutions.

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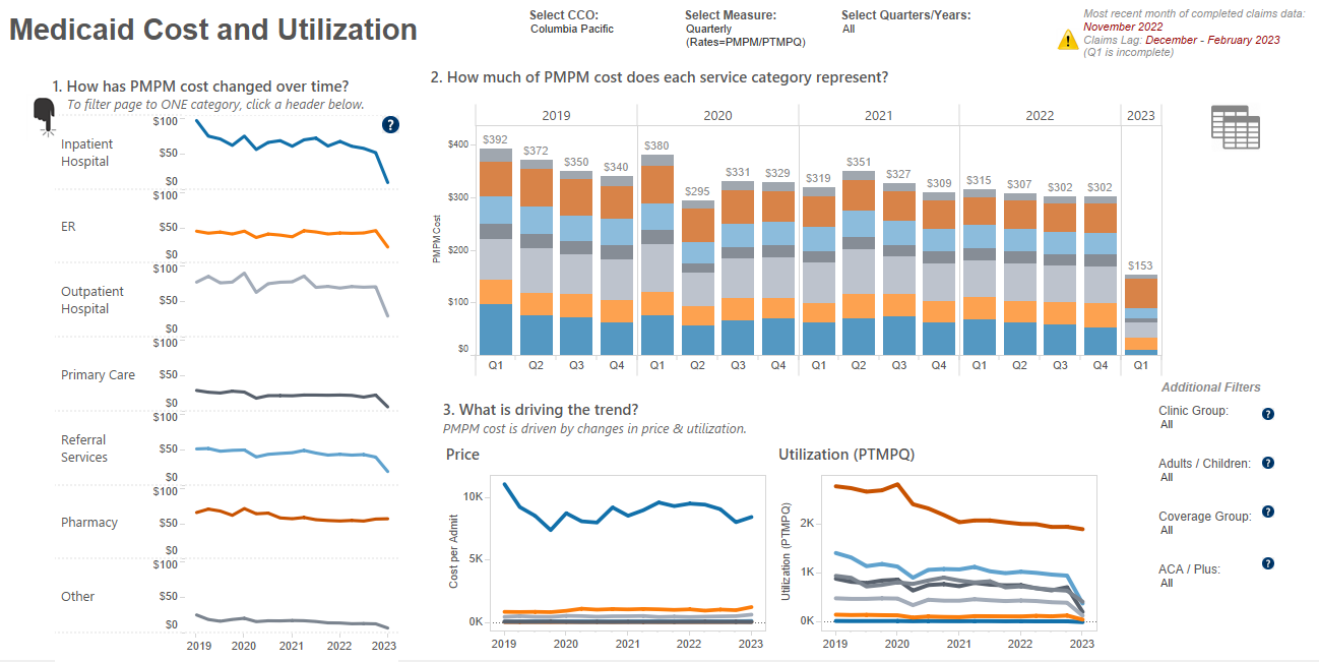

Individual cases may also be flagged for review by our Medical Management team and are subsequently reviewed by our team of Medical Directors and/or through our Peer Review committee, depending on the case.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

In 2019-2021, diabetes was the episode of care with the third highest costs ($18.66 million) and second highest for costs associated with adverse avoidable expenses ($7.62 million or 41% of total costs) according to current Optumas data. When we look at highest drivers of AAE costs, we see that the top three diagnosis for AAE spend are type I diabetes with ketoacidosis without coma (E1010), Type I diabetes with hyperglycemia (E1065), and type II diabetes with other specified complications (E1169). This suggests that CPCCO members with diabetes are experiencing challenges in managing their diabetes. In Columbia County, we have a Community Paramedicine program with the purpose of bringing chronic care management supports to members who experience barriers to accessing traditional health care models. The goals of this program are to:

- Improve access to chronic care management
- Increase patient ability to manage their chronic conditions

Given the cost findings above and the availability of a resource focused on improving care management, CPCCO determined that there was an opportunity to connect a specific cohort of patients with the resource.

Our plan was to implement changes that we believed would improve engagement in the DM program as described in last year's report. Briefly, a CareOregon Regional Care Team (RCT) pharmacist would review a weekly report that lists members with low medication adherence (defined using the ACG Medication Possession Ratio indicator, or MPR). Members with a MPR <0.75 would receive a medication review. After the pharmacists' review, and as indicated, there would be a referral to the community paramedic. The community paramedic would work with the member to implement the recommendations from the pharmacist medication review,

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assist with any system navigation concerns, co-create a diabetes management plan with the member, and provide counseling on behavior change to help support the member in managing their diabetes.

The RCT Pharmacy intervention did not happen as planned in 2022 due to minimal RCT Pharmacy Capacity and the reporting mechanism intended to inform member outreach (ACG Medication Possession Ratio indicator) was not built and ready for use until September 2022. However, even with limited capacity, the RCT Pharmacist did makes efforts towards longitudinal support for a select cohort of members with low medication adherence and a diabetes diagnosis, utilizing preliminary data from other sources.

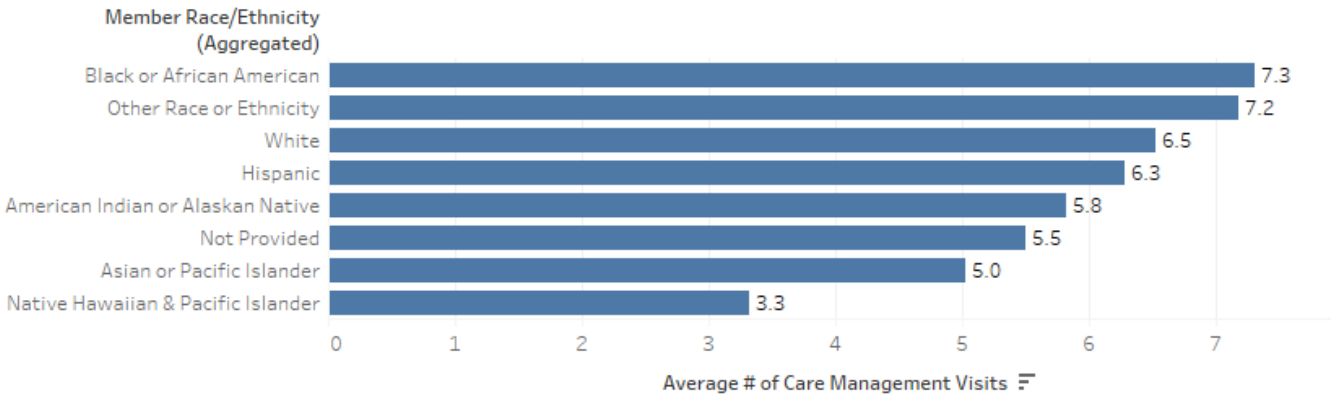
Given that we were unable to implement the strategy as intended, we did not meet our 2022 success indicator:

- 50% of members referred to the community paramedic engage in the DM Management Program, defined as completing at least 4 visits with the community paramedic.

However, we were able to begin regularly monitoring the number of care management visits for members with a diagnosis of diabetes enrolled *in any program*. Below is a summary of data available from April 1 to December 31, 2022:

- 2,701 CPCCO member with Diabetes Diagnosis
- 56 members with diabetes diagnosis AND RCT Pharmacy program labeled “Medication Adherence Support”
- 15 members with diabetes diagnosis AND RCT Pharmacy program labeled “MTMP”
- 19 members with diabetes diagnosis AND involved with Community Paramedicine

The graph below shows the average number of care management visits for members enrolled in any of the programs listed above with a diabetes diagnosis categorized by race/ethnicity.



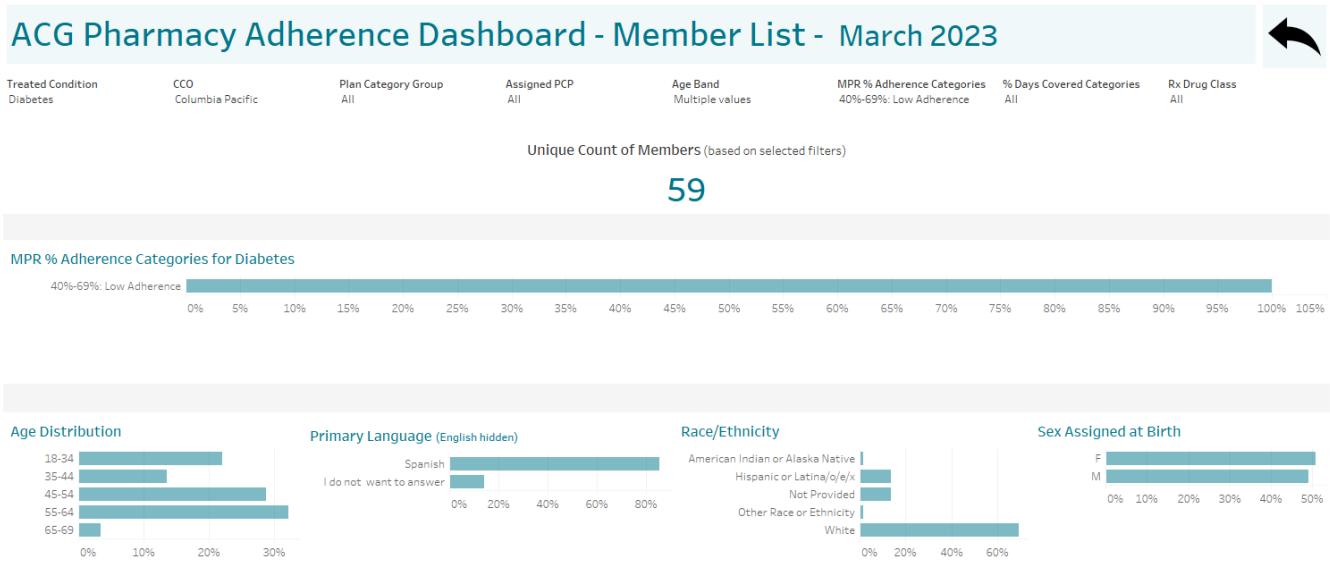
While we have been using the Optumas data supplied by the OHA at an aggregate level to identify opportunities within AAE, we have struggled to make the member-level data actionable since it is not currently tied to other data sources in our Enterprise Data Warehouse (EDW). Given that, we are unable to group members using this dataset in ways that are aligned with other analyses and programs. In addition, we currently find the greatest value in using member-level data to drive actionable outreach. The member-level data supplied in Optumas is not as current as data we have internally. Therefore, we have been able to do more meaningful, robust analysis using our own member-level data to drive strategy implementation.

Given that this is a continuation of last year’s project, we anticipate approximately the save savings as previously reported.

E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

For 2023, we plan to fully implement the strategy as previously intended:

A CareOregon Regional Care Team pharmacist will review the, now existing, weekly report that lists members with low medication adherence (defined using the ACG Medication Possession Ratio indicator, or MPR). Members with a MPR 40% to 69% and a diagnosis of diabetes will receive a medication review and is the population of focus. In the case that the RCT Pharmacist capacity becomes more limited than initially expected, the Pharmacist will filter the ACG MPR Dashboard to prioritize Medication Reviews for members with ethnicities indicated as non-white. An example summary dashboard, excluding member-level detail, is shown below. This same data will be used to monitor changes over time.



After the pharmacists' review, a referral will be made to the Community Paramedicine program. The community paramedic will work with the member to implement the recommendations from the pharmacist medication review, assist with any system navigation concerns, co-create a diabetes management plan with the member, and provide counseling on behavior change to help support the member in managing their diabetes.

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

Performance Measurement Strategy:

Monitoring Measure 1.1

- Numerator definition: Adult members (18+) with diabetes and a MPR 40% to 69% who received a medication review
- Denominator definition: Adult (18+) members with diabetes and a MPR 40% to 69%.
- Measurement period: April 1, 2023 – December 31, 2023
- Baseline period and population: Adult (18+) members with diabetes and a MPR 40% to 69% (August 1, 2022-March 31, 2023)

Monitoring Measure 1.2

- Numerator definition: Adult members (18+) with diabetes and a MPR 40% to 69% who received a medication review and outreach from a community paramedic after referral
- Denominator definition: Adult members (18+) with diabetes and a MPR 40% to 69% who received a medication review and a referral to community paramedic was made
- Measurement period: April 1, 2023 – December 31, 2023
- Baseline period and population: Adult (18+) members with diabetes and a MPR 40% to 69% (August 1, 2022-March 31, 2023)

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

RCT Pharmacist will perform Medication Reviews informed by the ACG Medication Possession Ratio Indicator Dashboard and, for members living in Columbia County, place referrals to Community Paramedic as indicated by member needs.

☒ Short term or ☐ Long term

Monitoring measure 1.1	% of members with diagnosis of diabetes and MPR 40% to 69% receiving a Medication Review by RCT pharmacist			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	50%	12/2023	75%	12/2024

Activity 2 description (continue repeating until all activities included): RCT Pharmacist and Community Paramedicine program collaborate on diabetes intervention, care planning and education. Community Paramedic works to align caseload with recommendations from RCT Pharmacist and provides outreach to referred members.

☒ Short term or ☐ Long term

Monitoring measure 2.1	% of members referred by RCT Pharmacist receiving outreach by community paramedic			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0%	25%	12/2023	50%	12/2024

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed. For full TQS requirements, see the TQS guidance document.)

A. Project short title: MEPP 1: SUD services in the Emergency Department

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

If continued, insert unique project ID from OHA: OHA MEPP Project #1 (new TQS project, but continued MEPP project)

B. Components addressed

a. Component 1: Utilization review
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☐ No
e. If this is a social determinants of health & equity project, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this is a CLAS standards project, which standard does it primarily address? Choose an item
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C. Component prior year assessment: Include calendar year assessment(s) of your CCO's work in the component(s) selected with CCO- or region-specific data and REALD data. This is broader than the specific TQS project.

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Per TQS guidance, this section contains a brief overview of CPCCO's utilization review process. Information specific to the proposed project is contained in the following section.

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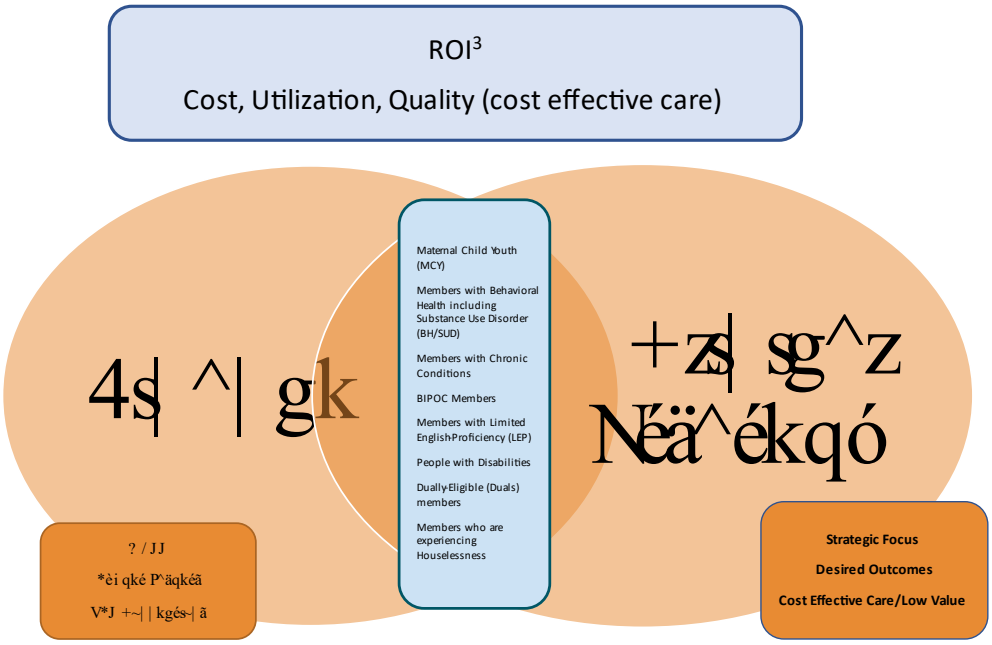

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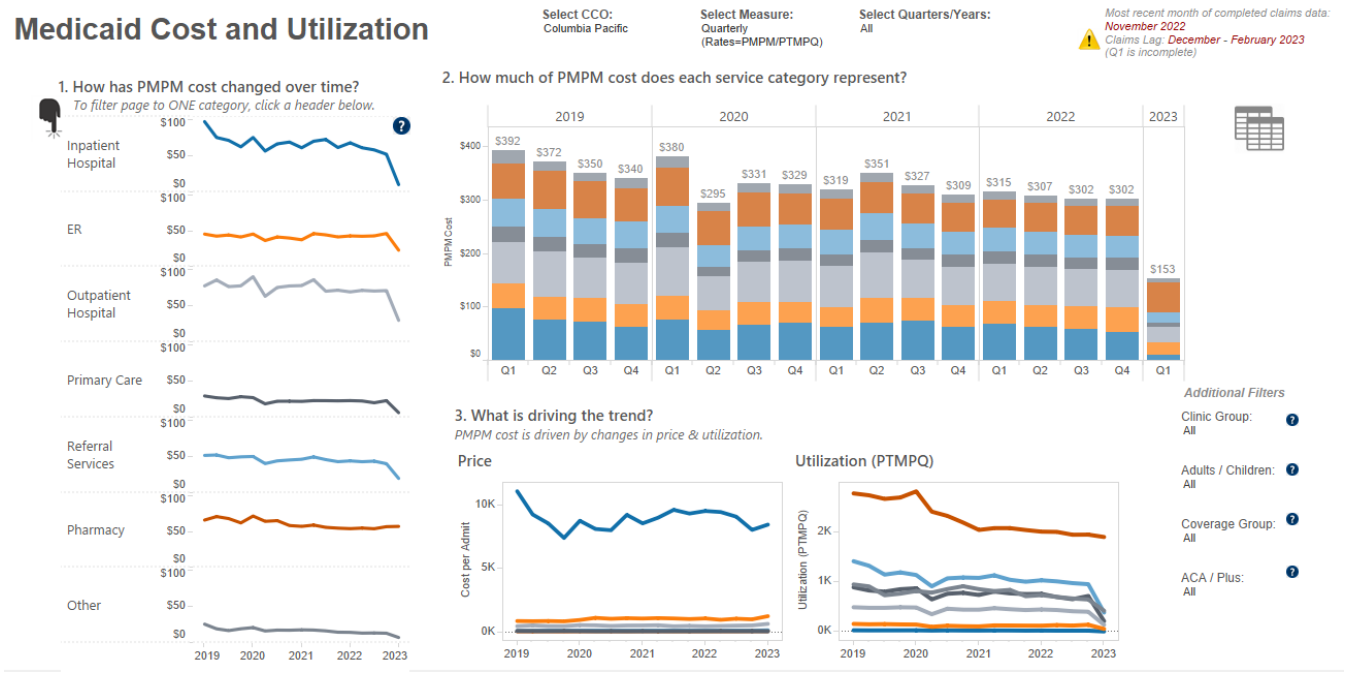

Individual cases may also be flagged for review by our Medical Management team and are subsequently reviewed by our team of Medical Directors and/or through our Peer Review committee, depending on the case.

D. Project context: For new projects, include justification for choosing the project. For continued projects, provide progress to date and describe whether last year's targets and benchmarks were met (if not, why not), including lessons learned. Include CCO- or region-specific data and REALD and SOGI data.

Within the CPCCO region, SUD episodes of care account for the highest proportion of Avoidable Adverse Expense (AAE) costs (39%). Among SUD episode subtypes, Alcohol Use and Opioid Use and Dependence are among the top three drivers of AAE costs, accounting for 56.8% and 10.4% of total SUD AAE costs.

Typical and PAC Costs by Episode Subtype and Member ID
(Click to Filter)

		Typical	AAE
Alcohol Abuse	ID Redacted	$6,312,221	$4,898,570
Opioid abuse/dependence	ID Redacted	$1,588,733	$894,421

AUD and OUD both contribute to Adverse Avoidable Expense (AAE) costs associated with hospital utilization associated with septicemia, overdoses, withdrawal, and the impact of long-term dependence on other organs and systems. Members with such diagnoses frequently present at the Emergency Department and at a higher level of acuity and severity; specifically, the biggest drivers of AAE spend are ED visits, hospital observation stays, transport by EMS, and imaging related to AUD and OUD. According to OHA's Opioid Overdose Public Health Surveillance Update in January 2023 Oregon's total number of opioid overdose visits to EDs and Urgent Care centers in 2022 are higher than previous years.

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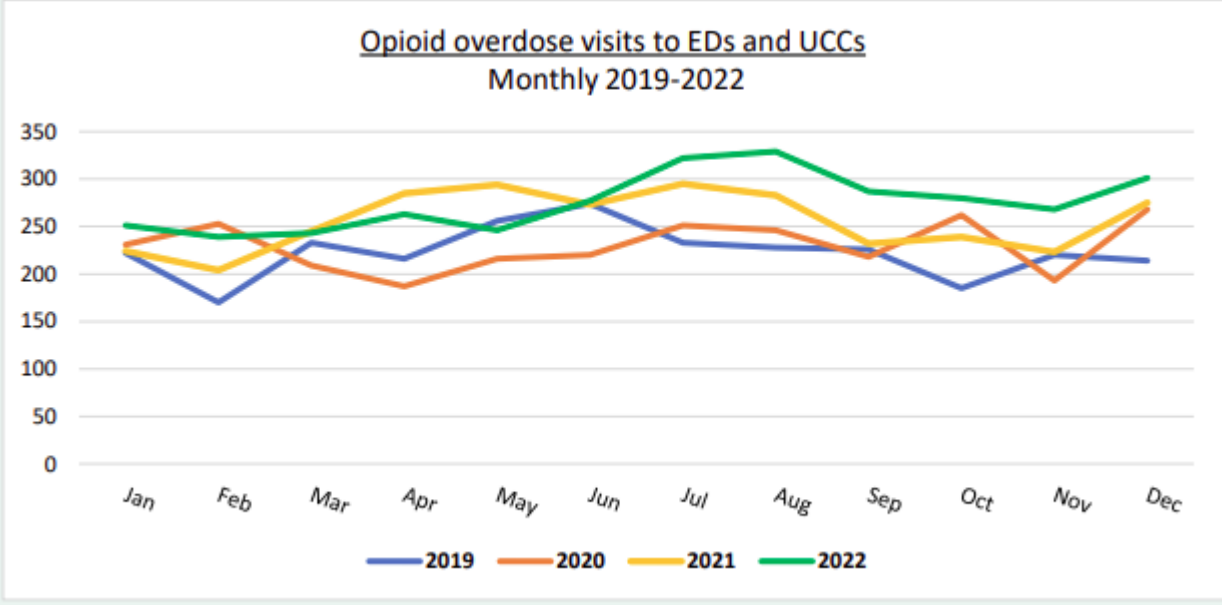
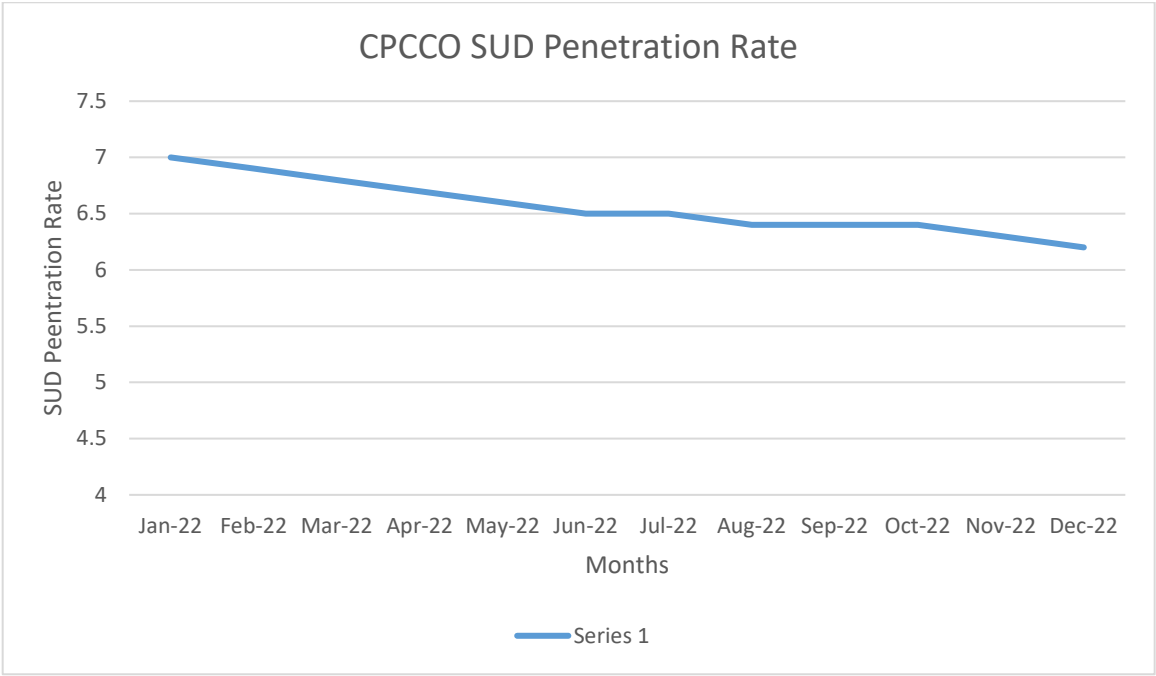


During 2022, we continued to see overall utilization drop in response to the COVID pandemic and related restrictions; however, the impact of the COVID pandemic persisted and resulted the continued in ED visits for overdoses, which points to evidence of the Behavioral Health (BH) epidemic that has unfolded within the global COVID pandemic. Based on the current state of the Behavioral Health ecosystem in our region, and statewide, much of our work in 2022 has been focused on sustaining our BH network as it is stretched beyond capacity. Additionally, we concurrently observed an increase in referrals to our Regional Care Team for BH supports and needs and worked closely in partnership with our BH network to address referrals concerns.



Despite the continued constraints and challenges, there was positive movement in some areas including CPCCO's involvement in the building of an Opioid Use Disorder Treatment Toolkit for Oregon Emergency Departments in partnership with the Oregon Health Leadership Council (OHLC). The toolkit provides a basic framework for EDs that want to build or strengthen their OUD treatment programs and offers Oregon-specific

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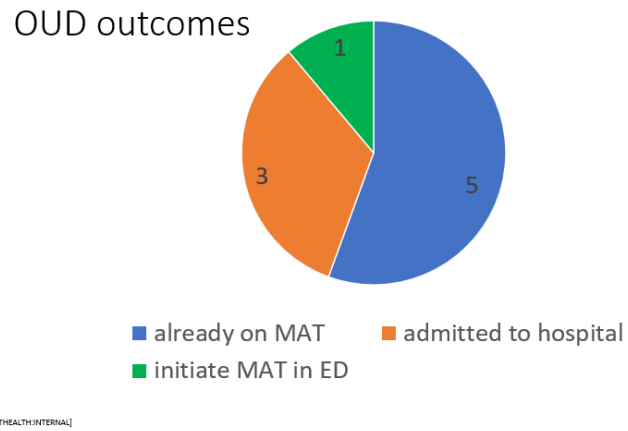
resources and examples that can help support their success. CPCCO's medical director is chair of the OHLC SUD workgroup, who created the toolkit.

In 2022, the specific aims of this project were to:

- Pilot MAT initiation at the ED and connection to a peer support specialist for support/follow up post discharge at one hospital; and
- Develop a workflow for our Regional Care Team to review all hospital events for SUD related concerns, including overdose events, to ensure the member received counseling on MAT treatment availability and harm reduction services, has a follow up appt with their primary care provider, and connection to a local peer support specialist.

The first goal was accomplished through our partnership with Adventist. Adventist Tillamook ED leaned into MOUD initiation during 2022 and presented their workflow at the CPCCO Clinical Advisory Panel in June. At that time, they shared early outcomes including the successful initiation of MOUD in the ED for one member, as shown below. Given the relatively low uptake, we still have opportunities to partner more closely with Adventist Tillamook, and improve/refine protocols, but are encouraged by this initial step.



[ADVENTISTHEALTH:INTERNAL]

We were unable to achieve the second goal to fidelity due to capacity issues. However, we developed a program and process for the Regional Care Team to outreach to cohort of members experiencing overdose. Though some of these members were enrolled into our RCT care coordination services, we were unable to fully implement the proactive approach for all members with an OUD diagnosis.

Even though strategy implementation focused more narrowly on OUD, our 2022 target outcomes were:

- 50% of members with a SUD who present to the ED with a SUD related concern to receive counseling on MAT treatment, and harm reduction services, including referral to a Peer, if available
- 20% of qualified members initiate MAT in the ED

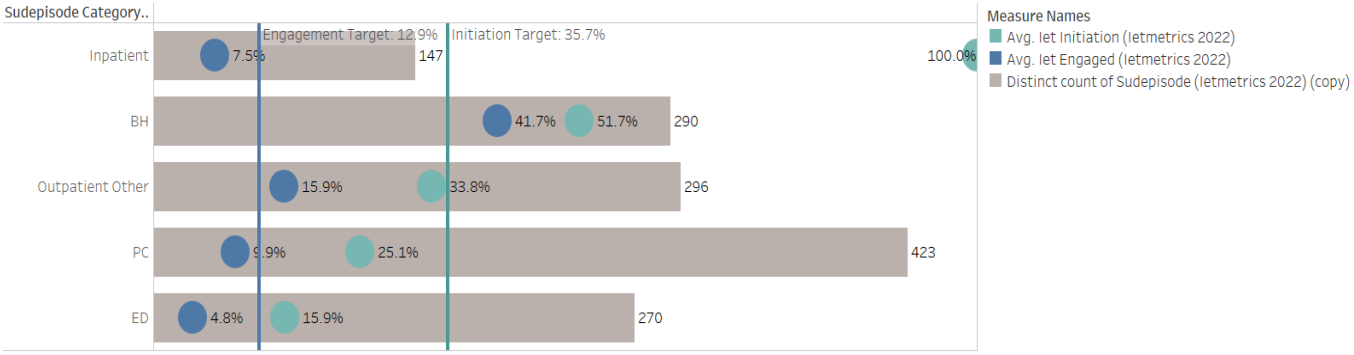
We did not meet these target outcomes but have continued to review available data to ensure that our efforts are still directionally correct. Data below shows both progress in the initiation of MOUD in one area hospital, as described above, and also much opportunity for bolstering work in other hospital systems.

payToProvider	SUD Dx (group)	cptCd (group MAT) Count of Distinct Claims MAT	Count of Distinct Claims No MAT	Count of Distinct Members MAT	Count of Distinct Members No MAT
ADVENTIST HEALTH TILLAMOOK	Alcohol Related Disorder		87		61
	Opioid Related Disorder	6	26	5	25
	Other Stimulant Related Disorder		33		22
COLUMBIA MEMORIAL HOSPITAL	Alcohol Related Disorder		157		85
	Opioid Related Disorder		24		17
	Other Stimulant Related Disorder		62		45
PROVIDENCE SEASIDE HOSPITAL	Alcohol Related Disorder		80		46
	Opioid Related Disorder		19		18
	Other Stimulant Related Disorder		15		12
Grand Total		6	503	5	308

cptCd (group MAT)
MAT
No MAT

Count of Distinct Claims and Count of Distinct Members broken down by cptCd (group MAT) vs. payToProvider and SUD Dx (group). Color shows details about cptCd (group MAT). The data is filtered on CCO and claimLineStartDate (Custom SQL Query2). The CCO filter keeps Columbia Pacific. The claimLineStartDate (Custom SQL Query2) filter ranges from 1/1/2022 to 12/31/2022. The view is filtered on SUD Dx (group) and payToProvider. The SUD Dx (group) filter keeps Alcohol Related Disorder, Opioid Related Disorder and Other Stimulant Related Disorder. The payToProvider filter keeps ADVENTIST HEALTH TILLAMOOK, COLUMBIA MEMORIAL HOSPITAL and PROVIDENCE SEASIDE HOSPITAL.

Further, we have recognized the need to expand the scope of this project to include SUD more broadly as opposed to focusing only on OUD. There is clearly an opportunity to improve initiation and engagement rates within the ED and IP settings as shown below. We also identified opportunities specific to Naloxone prescribing practices, which is described further in the next section. Last, expanding this project will also ensure that we are maximizing the number of AAE within scope.



Distinct count of Sudepisode (Ietmetrics 2022) (copy), distinct count of Sudepisode (Ietmetrics 2022) (copy), Avg. Iet Initiation (Ietmetrics 2022) and Avg. Iet Engaged (Ietmetrics 2022) for each Sudepisode Category (Ietmetrics 2022). Color shows details about distinct count of Sudepisode (Ietmetrics 2022) (copy), Avg. Iet Initiation (Ietmetrics 2022) and Avg. Iet Engaged (Ietmetrics 2022). For pane Distinct count of Sudepisode (Ietmetrics 2022) (copy): The marks are labeled by distinct count of Sudepisode (Ietmetrics 2022) (copy). For pane Measure Values: The marks are labeled by distinct count of Sudepisode (Ietmetrics 2022) (copy), Avg. Iet Initiation (Ietmetrics 2022) and Avg. Iet Engaged (Ietmetrics 2022). The data is filtered on Cco (Ietmetrics 2022) and Age current. The Cco (Ietmetrics 2022) filter keeps Columbia Pacific. The Age current filter includes values greater than or equal to 18.

We are also continuing to explore where there may be disparities in care as illustrated below.

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Location of SUD Diagnosis	Primary Language	Average Rate of IET Initiation	Average Rate of IET Engagement
BEHAVIORAL HEALTH SETTING	ENGLISH	46.4%	38.5%
	OTHER - NOT SPECIFIED	0.0%	0.0%
	SPANISH	0.0%	0.0%
EMERGENCY DEPARTMENT SETTING	ENGLISH	15.8%	4.6%
	I DO NOT WANT TO ANSWER	0.0%	0.0%
	OTHER - NOT SPECIFIED	0.0%	0.0%
	SPANISH	0.0%	0.0%
INPATIENT SETTING	ENGLISH	100.0%	8.3%
	SPANISH	100.0%	0.0%
OUTPATIENT OTHER SETTING	ENGLISH	34.8%	15.2%
	OTHER - NOT SPECIFIED	0.0%	0.0%
PRIMARY CARE SETTING	UNKNOWN	0.0%	0.0%
	ENGLISH	25.0%	8.9%
	SPANISH	0.0%	0.0%

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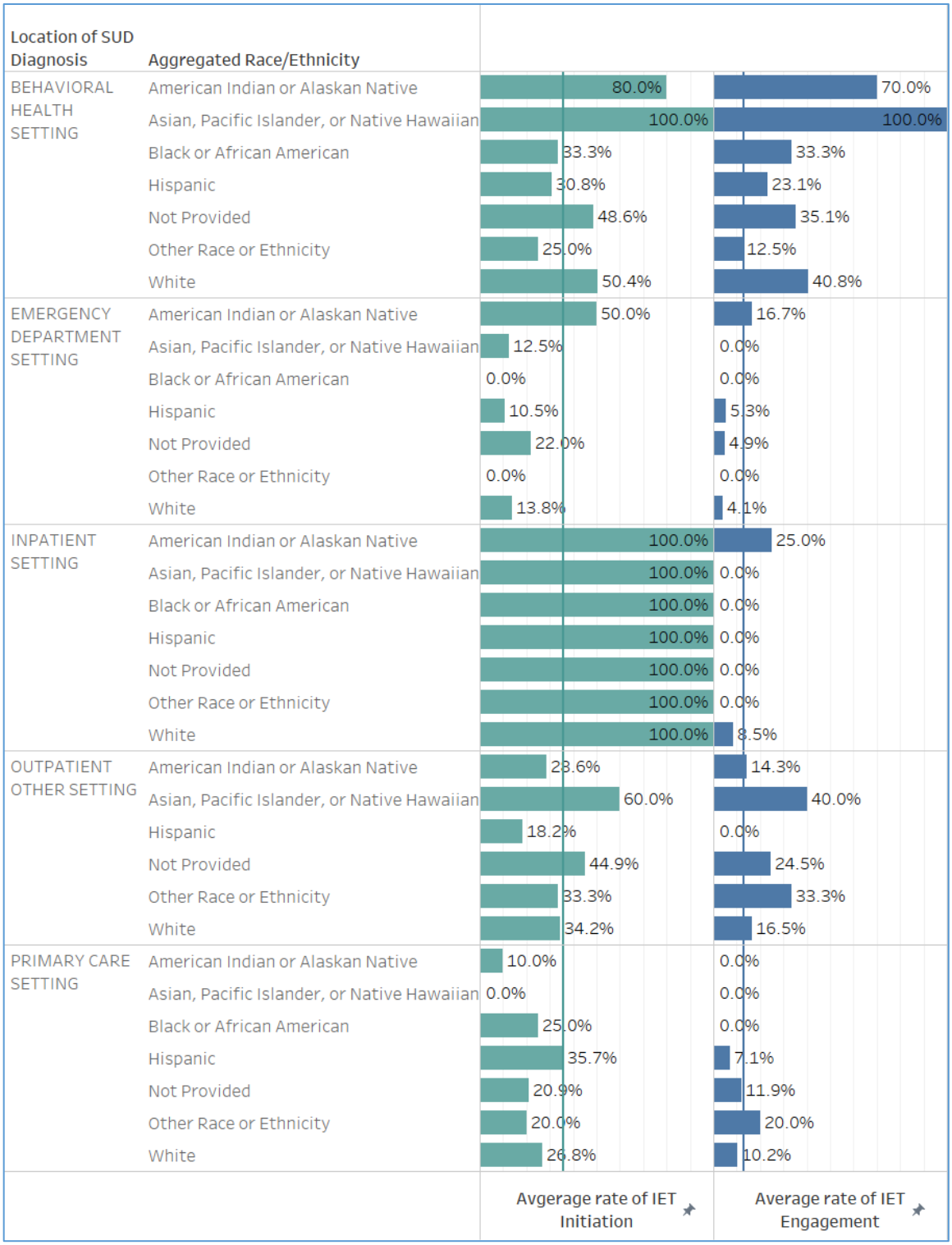


While we have been using the Optumas data supplied by the OHA at an aggregate level to identify opportunities within AAE, we have struggled to make the member-level data actionable since it is not currently tied to other data sources in our Enterprise Data Warehouse (EDW). Given that, we are unable to group members using this dataset in ways that are aligned with other analyses and programs. In addition, we currently find the greatest value in using member-level data to drive actionable outreach. The member-level data supplied in Optumas is not as current as data we have accessible internally. Therefore, we have been able to do more meaningful, robust analysis using our own member-level data to drive strategy implementation.

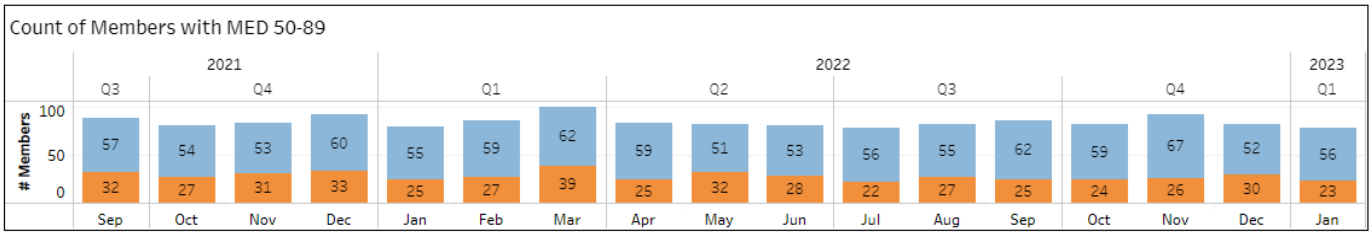
We have not conducted another financial analysis since expanding the scope of this project. Last year, we estimated a potential savings of $1.27 million, specific to ED visits and overdoses. We anticipate that the potential savings is at least this much given a similar, but broader, scope.

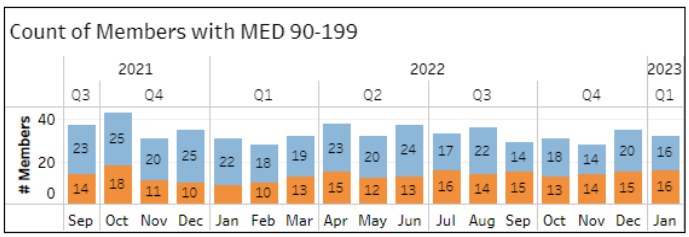
E. **Brief narrative description**: Brief, high-level description of the intervention that addresses each component attached and defines the population.

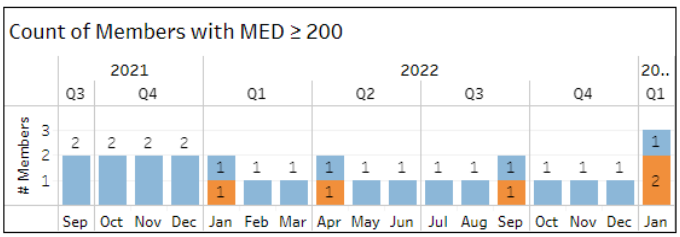
The intervention will be focused on increasing engagement in SUD services (for AUD, OUD, and stimulant use disorder), including Medication for Opioid Use Disorder (MOUD) among those with a SUD dx who have had an ED visit or IP admit related to their SUD (i.e., overdose, withdrawal, etc.). Adventist ED began this work in 2022, as previously mentioned. We will offer support to strengthen their current ED initiation and bridging workflow with of a goal of incorporating referral workflows to ongoing supports including peers. We will also explore building close partnership with another hospital partners in our region to begin piloting SUD services, and MOUD initiation at the ED in alignment with OHLC's new OUD Treatment Toolkit for Oregon Emergency Departments.

Additionally, we will revisit and refine the workflow developed in 2022 for our Regional Care Team. It will expand to include review of all hospital events for SUD related concerns, including overdose events. to ensuring members receive counseling on SUD services, SUD treatment availability, and harm reduction services, has a follow up appt with their primary care provider, and connection to a local peer support specialist. Further, we will explore options for systematically tracking member outreach and engagement connected to this workflow.

We will also begin focusing on increasing naloxone prescribing as well as MAT for alcohol use disorder. This has been an area of focus with our Clinical Advisory Panel. We presented baseline data regarding naloxone co-prescribing and identified opportunities for improvement (see below). This data will be integrated into our QI workgroup, and conversations with clinics as opportunities to expand naloxone access within our membership, in order to prevent overdose.







Monitoring medication treatment for AUD and expanding regional knowledge of evidence based best practice in treating AUD, can help to improve treatment and management of AUD in our population. The OHLC SUD workgroup also developed an AUD treatment tips and tricks, which we will use to increase knowledge of AUD treatment in our region. In addition, we will work with our clinical partners to ensure best practice regarding AUD treatment is offered to patients struggling with AUD.

We are modifying last year's goals to better align with OHA measure sets as well as all of the activities above. Our indicators of success are:

- 20% of members who present to the ED with a SUD diagnosis will initiate treatment
- 7% of members who present to the ED with a SUD diagnosis will be engaged in treatment
- 100% of members with a SUD diagnosis and IP admission will initiate treatment
- 10% of members with a SUD diagnosis and IP admission will be engaged in treatment
- 11% of members with a SUD diagnosis and primary care visit will initiate treatment
- 30% of members with a SUD diagnosis and primary care visit will be engaged in treatment

Through the activities above, the population of focus will be members with an ED visit or IP admission with diagnosis of SUD and members with AUD who would benefit from MAT.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Build partnership with hospital partners to increase engagement in SUD services among those with a SUD dx who have had an ED visit or IP admission.

☒ Short term or ☐ Long term

Monitoring measure 1.1	# of hospitals in service area providing MAT initiation in ED			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
1	2	12/2023	3	12/2024
Monitoring measure 1.2	% of members 18 and older with a new diagnosis of alcohol or other drug use who present at the ED and initiate treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
15.9%	20%	12/2023	35.7%	12/2024
Monitoring measure 1.3	% of members 18 and older with a new diagnosis of alcohol or other drug use who present at the ED and are engaged in treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
4.8%	7%	12/2023	12.9%	12/2024
Monitoring measure 1.4	% of members 18 and older with a new diagnosis of alcohol or other drug use with an inpatient admission and initiate treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
100%	100%	12/2023	100%	12/2024

Monitoring measure 1.5	% of members 18 and older with a new diagnosis of alcohol or other drug use with an inpatient admission and are engaged in treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
7.5%	10%	12/2023	12.9%	12/2024

Activity 2 description: Collaborate with provider partners on sharing best practices and data on prescribing for alcohol use disorder.

☒ Short term or ☐ Long term

Monitoring measure 2.1	MAT report			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
MAT report not automated	MAT report automated	06/062023	MAT report automated	06/2023
Monitoring measure 2.2	MAT data sharing			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
MAT data shared irregularly	MAT data shared with network on regular cadence	07/2023	MAT data shared with network on regular cadence	07/2023
Monitoring measure 2.3	% of members 18 and older with a new diagnosis of alcohol or other drug use who present in primary care and initiate treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
25.1%	30%	12/2023	35.7%	12/2024
Monitoring measure 2.4	% of members 18 and older with a new diagnosis of alcohol or other drug use who present in primary care and are engaged in treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9.9%	11%	12/2023	12.9%	12/2024

Section 2: Discontinued Project(s) Closeout

(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: Equity Data Guidelines
B. Project unique ID (as provided by OHA): 74
C. Criteria for project discontinuation: Fully matured project that has met its intended outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): The intention of this project was to build internal capabilities around understanding how to disaggregate data and use that data to make informed decisions on interventions. To that end we worked hard to create guidelines for all data analysts and to train any staff using the dashboards created by those analysts on best practices when reviewing REALD data. Having now established that skill set amongst our team we would like to pivot our focus to projects that work on the application of REALD and/or SOGI data.

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Section 2: Discontinued Project(s) Closeout

(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: Expanding Transition Support to Observation Patients

B. Project unique ID (as provided by OHA): 418

C. Criteria for project discontinuation: Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Upon reviewing OHA's feedback on this project we realized it made much more sense to integrate the Model of Care work that CareOregon has been spearheading for their CareOregon Advantage DSNP patients. We believe that project is a better demonstration of data utilization that directly leads to patient supports and care plans.

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Section 3: Required Transformation and Quality Program Attachments

Required quality program attachments TQS is an important part of your organization's larger Quality Assurance and Performance Improvement (QAPI) program, but it does not represent the entirety of your QAPI work. Please include the documentation listed below to help us better understand your overall quality program.

A. Please attach the following documentation about your organization's quality program:

1) Quality Assurance and Performance Improvement (QAPI) Workplan

2) QAPI Impact Analysis • This narrative analysis should summarize QAPI work in the prior year, including successes, issues and barriers identified, and explain how your organization will use QAPI to minimize barriers and resolve issues in the year to come.

References: • §438.330 Quality assessment and performance improvement program • 410-141-3525 – Outcome and Quality Measures (11) • 410-141-3590 – MCE Member Relations: Member Rights and Responsibilities (1) • 410-141-3705 – Criteria for CCOs (26)(c) • 410-141-3915 – Grievances and Appeals: System Recordkeeping (5) • Exhibit B – Statement of Work: Part 10 Transformation Reporting, Performance Measures and External Quality Review, Sec 2 and 7

B. Optional: Supporting information

Supplemental documentation is not intended as a replacement for analysis or a comprehensive response within the TQS. In the table of contents, please clarify which Section 3 attachments are intended to address quality program requirements or supplement specific projects. Please include document title, page number(s) and project number (if relevant).

Information could include but is not limited to:

✓ CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS

✓ CCO organizational charts, policies and procedures

✓ Project-specific attachments: Component or project-focused driver diagrams, root-cause analysis diagrams, data to support project problem statements.

• All project-specific supplemental documents must reference which project the document is supplementing. This must be noted in both the TQS template for that project and the supplemental document's content.

• Combine the TQS submission and all attachments into a single PDF.

2023 Quality Assurance and Performance Improvement Work Plan

Focus Area	Planned Activities	Cadence/Timing	Owner
Access & Availability	Review provider access and wait time	Quarterly	VP, QIS
	Review DSN Narrative/OHA Evaluation	July	VP, QIS
	TQS Project Monitoring (components related to access)	March, Sept	VP, QIS
	Monitor 2021 & 2022 CMR Findings & Improvement Plans	July	Dir, Quality of Care
Utilization Management (QAPI)	Monitor/analyze referrals, pre-auths, NOAs, appeals, hearings	Quarterly	Sr Med Dir, VP Clin Ops
	Monitor 2020, 2021, 2022 Cov & Auth EQR Findings and Improvement Plan	Feb, Sept	Dir, Quality of Care; Dir Clin Ops
	TQS UR /UM Project Monitoring/ MEPP	March, Sept	VP, QIS
	Escalation Pathway for QBR	ad hoc	Dir, Quality of Care; VP Clin Ops
Grievances & Appeals (QAPI)	Monitor, track, and trend grievances to develop action plans for reduction of grievances through education and support	Quarterly	VP, Clin Ops
	TQS G & A Project Monitoring	March, Sept	VP, QIS
CCIP (CMS)	Monitor quarterly; annual attestation to CMS	Quarterly	Dir, Quality of Care
Model of Care and SHCN/LTSS Monitoring (QAPI, CMS)	Quarterly MOC Report	Quarterly	VP, PHP
	Duals Integration Project	TBD	VP, PHP
	TQS Project Monitoring (components with SHCN/SDoH/pop health)	March, Sept	VP, QIS
	Submission Review; intervention if required for <70 score	February	VP, PHP
Language Access/Equity	Language Access Steering Committee Participation	Monthly	Dir, Quality of Care
Member Experience	Review CAHPS results, establish thresholds for performance and identify opportunities for improvement	needs discussion	VP, CX
	Member Satisfaction Analysis	Quarterly	VP, CX
	Escalation Pathway for QBR	ad hoc	
2023 Policy Approvals	Review and approve per policy approval process as reviewer group	ad hoc	Dir, Quality of Care

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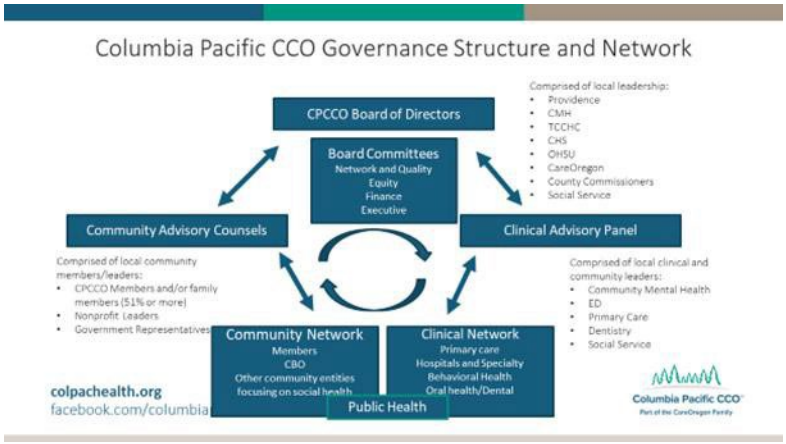
Focus Area	Planned Activities	Cadence/Timing	Owner
Enterprise Quality Management	Evaluate the effectiveness of the Quality Program to include monitoring activities and clinical, operational, and satisfaction initiatives.	Quarterly, then by March 15 of subsequent year	Dir, Quality of Care; VP, QIS
	Completion of 2023 Work Plan for enterprise	Jan-Feb	Dir, Quality of Care
	TQS	March and October	VP, QIS
Quality of Care Reviews	Track and trend issues; medical director group to determine how feedback/clinical support shall be provided	Peer Review Minutes to BoD, annual review Q4	Sr Med Dir, Ops
Clinical Practice Guidelines	Update and approve annually or every two years	COQHO	Med Dir, Quality
Clinical Quality Indicators (CCO Metrics & Star Measures)	Identify areas at risk for enterprise; allocate resources as necessary; provide support	Quarterly	Med Dir, Quality

QAPI Impact Analysis

The narrative below describes the Columbia Pacific quality program and approach, the role of its Network & Quality Committee relative to quality oversight and governance as well as clinical transformation and the TQS, and details about utilization review oversight, practice guidelines, and member rights and impact analysis. Supplemental documents include:

- Network & Quality Committee Charter and Work Plan
- Clinical Advisory Panel Charter
- CareOregon Enterprise Quality Work Plan

Overall Columbia Pacific CCO Quality Program and Approach Description:



As outlined in the CCO Governance Structure and Network graphic, the **Columbia Pacific Board of Directors** oversees the implementation of the strategic plan for Columbia Pacific CCO and is accountable for setting the CCO's performance expectations, which include success indicators and metrics for quality and transformation. The **Clinical Advisory Panel (CAP)**, at the direction of **Columbia Pacific Board's Network and Quality Committee**, provides the strategic leadership and direction for clinical transformation, including the projects for the TQS. The Network and Quality Committee provides direct oversight of the quality assurance aspects of the quality program. The CAP ensures Columbia Pacific's clinical transformation efforts and quality priorities are strategically aligned with those of its governing bodies of the CCO and its constituent organizations, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels. The CAP has developed a strategic approach to quality that combines the Columbia Pacific Board's strategic plan, the state directed contract requirements and TQS components, clinical priority initiatives, the Regional Health Improvement Plan, and Performance Improvement Projects (PIPs) into a defined set of well-articulated goals to improve and transform the health and wellness of the Columbia Pacific population (see figure below).

Figure 1

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The Columbia Pacific Network and Quality Committee provides direct oversight of delegated activities, quality

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assurance activities, and transformation activities. The Network & Quality Committee reviews the CAP's quality and transformation recommendations for investment approval, and it is responsible for reviewing quality assurance reports, findings, and actions. Every attempt is made to take findings related to quality assurance reports and develop quality improvement activities to ultimately improve health outcomes and care delivered to Columbia Pacific members (see quality program graphic below).

Our approach is to identify opportunities for improvement, through findings determined in regulatory quality submission processes, through continual data review, or through network and community input, and subsequently develop process improvement initiatives or programs to address these issues. The identification and review of the concerns/opportunities is reviewed with the Columbia Pacific Board's Network and Quality Committee, as well as the CAP. For large scale improvements, requiring broader resources and programmatic development, opportunities are also presented, and developed within the CareOregon Quality and Health Outcomes (COQHO) structure of CareOregon (details follow). In this way, we honor the space between quality assurance and quality improvement in service to improving health outcomes for our membership and addressing disparities.

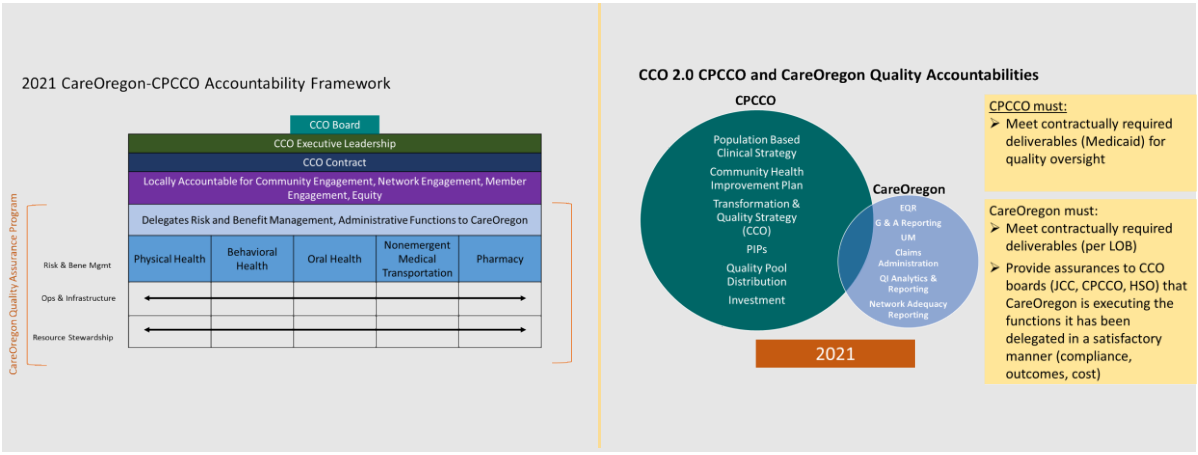
Columbia Pacific TQS Approach and Oversight:

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

Medical Director leads the CareOregon Quality Health and Outcomes Steering Committee, and partners closely with CareOregon Quality Assurance committees to provide alignment between Columbia Pacific and CareOregon.

The annual Columbia Pacific TQS process leverages the CareOregon quality governance structure and staffing to ensure Columbia Pacific consistently meets its contractually required OHA deliverables (see #2).

Figure 2



Senior CareOregon staff partner with the Columbia Pacific Leadership team to interpret the TQS requirements, establish timelines for completion, and ensure that TQS projects, programs, and performance improvement activities are aligned with the applicable OHA guidance and CCO contractual language. The Columbia Pacific Project Manager is responsible for creating content and overseeing deliverables for programs included in the TQS**.** The TQS is reviewed and executed by the Columbia Pacific CCO Clinical Advisory Panel (CAP) and, for relevant work, Columbia Pacific's local Community Advisory Councils (CACs). The report is ultimately reviewed and approved for submission by the Network and Quality Committee of the Columbia Pacific Board of Directors and CareOregon Quality Health Outcomes (COQHO).

Quality and Population Health: Overview of Relationship between Columbia Pacific and CareOregon:

Throughout 2022, CareOregon, Columbia Pacific's parent company, has further developed an overarching Quality and Population Health infrastructure to help guide and support the strategic initiatives within Columbia Pacific. This CareOregon Quality Health and Outcomes (COQHO) structure provides structural support, alignment, and leverages shared resources that are needed to do robust quality work, such as clinical prioritization, data, value- based payment, and care coordination.

This quality program is led by the Senior Medical Director of Clinical Services for CareOregon, who is also Medical Director of Columbia Pacific CCO. COQHO is directly accountable to the CareOregon board of directors, and the regional specific work, led by Columbia Pacific leadership, is directly accountable to the CCO governance structure (described above, and shown below).

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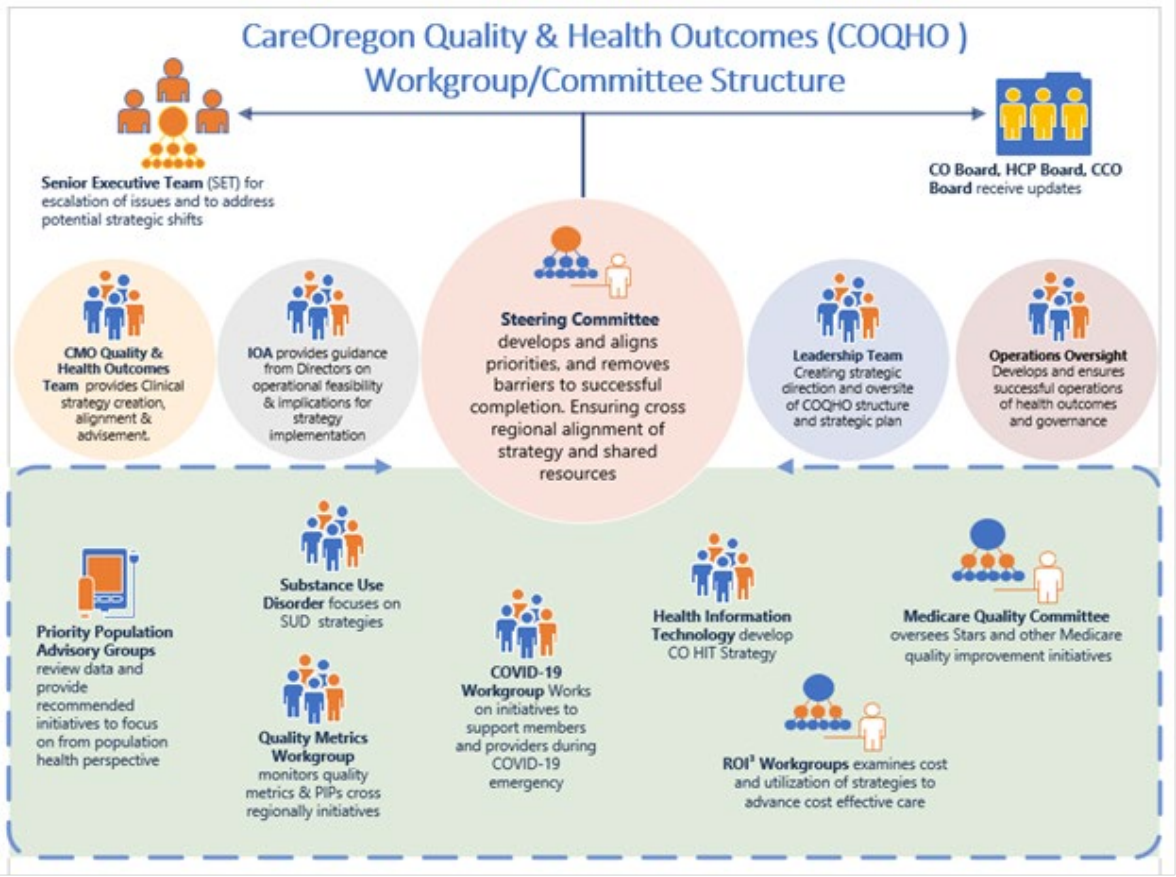


Throughout 2022, COQHO optimized the structure by defining its governance and oversight from a quality perspective. COQHO reports both to the Network and Quality committee of the CPCCO board, as well as to the Quality Health and Outcomes committee of the CareOregon board. We also have started a quality oversight subcommittee of COQHO to guide regulatory quality requirements and oversight.

In 2022 our areas of focus were:

1. Supporting our network in the post- COVID/Covid integration efforts related to access and workforce.
2. Focused SUD work to improve access to care for our members with SUD, expanding access to MAT (buprenorphine and sublocade)
3. Focusing on members with pediatric asthma and building a care management program, using a respiratory therapist and pharmacists for pediatric members with uncontrolled asthma.
4. Focusing on meeting OHA metrics, and assessing the needs related to pediatric BH, related to SEH.
5. Integrated oral health into our PCPM model to improve integration of oral health into primary care (first tooth and referral to dental services)
6. Development of care baby model to support our pregnant members

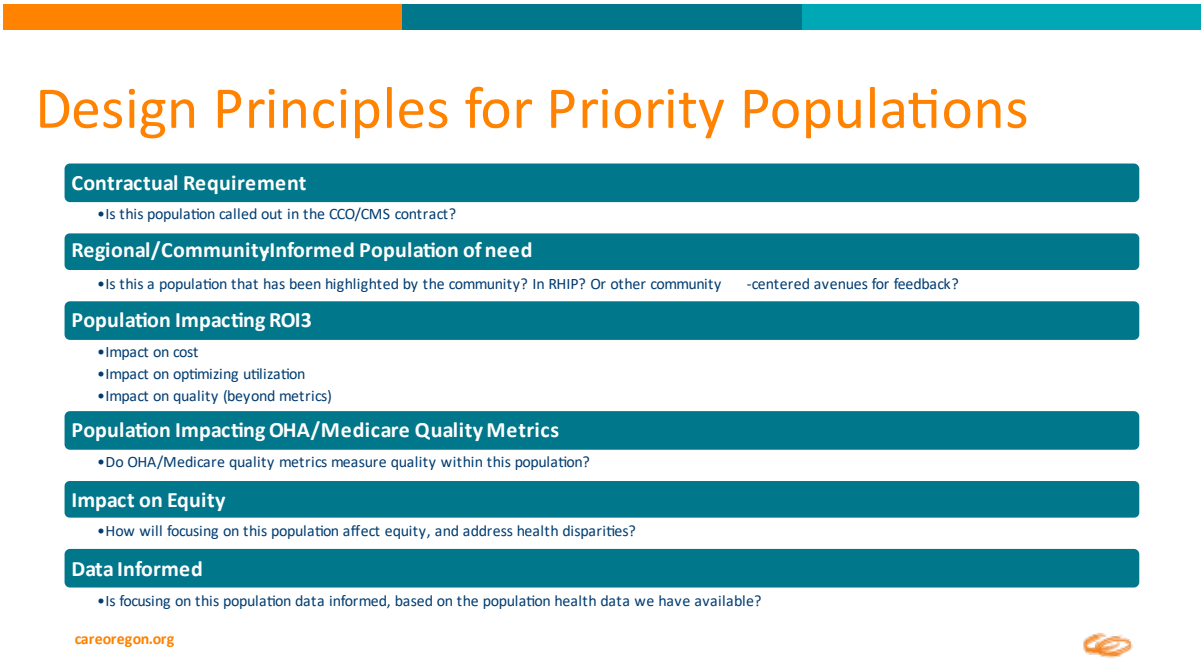
Our biggest success this year was getting the infrastructure in place to better align our population health, quality improvement, and quality metric strategies. Work toward this success was, in part, a response to one of our biggest on-going challenges: limited internal and external capacity. To-date, CPCCO has implemented many projects intended to address population health, regulatory requirements, or OHA/Medicare performance metrics. Often these individual efforts have similar focus but less coordination than needed to maximize internal efficiency and potential outcomes. Through restructuring governance within COQHO and taking the population approach described below, we will be better aligning

initiatives across the organization. This is intended to result in greater capacity to support individual projects, more robust reporting and evaluation, and ultimately better member outcomes.

As mentioned, we have developed an approach for CareOregon, and its affiliated CCOs, to collectively determine populations of focus based on regulatory requirements, population data, equity impact, alignment with OHA and Medicare metrics, and cost and utilization. We have structured our quality and population health leadership and team, to directly identify the populations of focus, and develop outcome and impact statements. This will be work moving forward in 2023-2025, based on OHA contractual requirements, new benefits, and greatest impact. Staff responsible for each QAPI component, as identified in the workplan (see QAPI workplan attachment), participate in each of the forums as indicated below and are the main points of contact for ensuring the work is developed and reviewed in accordance with the governance structure.

Meeting	Purpose	Attendees
CMO Quality and Health Outcomes Team	Clinical Prioritization and Benefit recommendations	Senior Medical Directors, LOB Medical Directors, **Benefit Leads** (benefit focus not department), QIS VP, and PHP VP
COQHO Steering Committee	Alignment of CO clinical priorities and LOB strategy	Regional and Medicare VP, Senior Medical Director (Safina), **Department Leads (BH, RX, Dental,)** (Department hat, not benefit leader hat), VP QIS, VP PHP
Integrated Ops and Alignment	Operational Feasibility	Directors across the enterprise

We have altered our approach to identifying which populations to focus on as described above and using the design principles below.



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Through this exercise the following priority populations and sub-populations were identified:

- Maternal, child, youth
    - Members who are 0-5 (early childhood); and members 6-14 (focusing on oral health)
- Members with uncontrolled chronic conditions
        - Co-existing DM/CAD/CKD
        - Advanced illness
        - Pediatric asthma
- Members with behavioral health diagnoses, including substance use disorder.
    - Members with SPMI
    - Members with SUD

We also determined that within each of these categories additional lenses would be applied to identify specific opportunities for:

- Black, indigenous, and people of color
- Individuals with limited English proficiency
- LGBTQ+ individuals
- Dually-eligible members
- People with disabilities
- People experiencing houselessness

Our next step will be to develop outcome and impact statements based on review of disaggregated data. This process is part of our overall quality strategy to improve health outcomes focused primarily on member needs and in alignment with OHA/Medicare quality metrics and requirements. The roadmap below illustrates how and when we intend to bridge this work. This entire approach will inform and guide our QAPI work moving forward.

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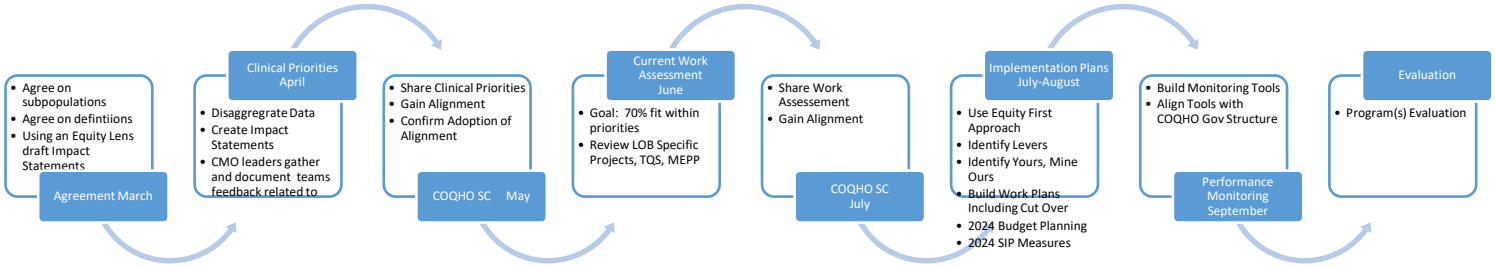


As discovered through the external review process, there are areas for improvement in our 2022 QAPI since the content of our 2022 TQS was submitted as our 2022 QAPI. Therefore, a full summary of project specific work, including progress and outcomes, is essentially the entirety of Section 1 of this report. We are currently working on additional improvements specific to our QAPI workplan and narrative, corresponding to the last external review results, which will be finalized April 2023.

Grievances and Appeals, Member Rights, Compliance and UM:

Columbia Pacific's grievances and appeals are managed by CareOregon. CareOregon's Quality Assurance Manager for Clinical Operations conducts a quarterly review of CareOregon's grievance system report and grievance and appeals log to assure that CareOregon is meeting its timelines for receipt, disposition, and documentation, is compliant with applicable OHP rules as well as internal key performance indicators. In addition, the QA Manager conducts a monthly qualitative review of complaints to identify notable trends in types or sources of complaints, provide opportunities for follow up as needed, and identify service recovery opportunities where warranted; this review is done in conjunction with routine quality audits done by appeals and grievance coordinators staff and supervisors. The qualitative review further serves as a mechanism to identify variations that trigger a root cause analysis of negative trends or events, as well as potentially identify Quality of Care concerns that are escalated to the Peer Review Committee and the Columbia Pacific CCO medical director.

The Quality Assurance Manager for Clinical Operations is also responsible for reviewing and analyzing trends related to appeals. On a monthly basis, a collaboration between the Grievance & Appeals staff, Utilization Management Department, Medical Directors, conducts a monthly review of the reason for overturned medical appeals and identify opportunities for improvement.

Compliance with contractual timeliness and response standards is reported monthly on the Compliance Dashboard, and the Columbia Pacific Network & Quality Committee receives a quarterly summary of complaints and appeals by Columbia Pacific members with year-end report summaries with trends and analysis presented to the committee annually.

Findings identified during the Compliance Monitoring Review are presented to the Columbia Pacific Board's Network and Quality Committee by CareOregon's Director, Quality of Care & Accreditation, who is responsible for ensuring that corrective action plans are executed and implemented as outlined in submitted improvement plans. The CareOregon Director, Quality of Care & Accreditation sits on the Columbia Pacific Network & Quality Committee as a non-voting member to keep the committee informed of progress on corrective actions and escalate barriers when necessary.

Columbia Pacific CCO monitors over and under-utilization by regularly reviewing a cost and utilization dashboard and maintaining a cost and utilization portfolio which highlights programs, projects and initiatives we are doing to address over and under-utilization. In the past, CareOregon had a robust Cost and Utilization Steering Committee, made up of many senior leaders coming together to review data and decide on priority initiatives to address cost and utilization. We have now transitioned from this structure to an ROI^3 committee (focusing on return on investment for cost, quality and access), to identify opportunities to impact the triple (or quadruple aim). In this committee we will focus on things such as identifying opportunities to address low value care, identifying how best to utilize our value-based payments to impact quality, or discussing and planning for interventions related to MEPP. In addition to this macro level review of cost and utilization trends, the CCO medical directors convene regularly with CareOregon Medical Management medical directors to analyze utilization trends and monitor utilization against clinical guidelines and evidence-based best practices to assure benefits are synced with the most appropriate clinical guidance, and support the provider network through training and data review of clinical best practices and review of prior authorizations, appeals, and overturns.

Columbia Pacific continually uses our quality program and overall quality improvement process to identify opportunities for improvement within our strategic initiatives, requests or directives from the network/CAP/CAC, and/or in response to findings related to regulatory requirements. Our Clinical Advisory Panel and Network and Quality Committee serve both to advise and approve clinical and quality improvement strategies, as well as to identify gaps in services, and opportunities for improvement.

Decisions to modify clinical practice guidelines or nationally recognized protocols are vetted through the CareOregon Quality & Health Outcomes Steering Committee (COQHO), on which the Columbia Pacific Medical Director leads and serves. If modifications are made, they are developed from scientific evidence or a consensus of health care professionals in a particular field. Columbia Pacific would seek out opinions and guidance with applicable providers in the event of an exception to a guideline. Whenever possible, guidelines are derived from nationally recognized sources that are evidence based. The current guidelines, derived from Institute for Clinical Systems Improvement (ICSI), are reviewed, and approved by COQHO at least every two years or when updates occur. All guidelines (modified or not) that are approved through COQHO are communicated to the Columbia Pacific CAP and are made available through the Columbia Pacific provider portal to all medical providers as needed.

Section 3: Optional supporting information

A. Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

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

Contents:

1. Supplemental materials for Project 73: Grievance and Appeals Member Form
2. Supplemental materials for Project 80: Appendix A – Clatsop County RCC Network Strategic Plan
3. Supplemental materials for Project 80: Appendix B – Columbia County CTIN Strategic Plan
4. Supplemental materials for Project 80: Appendix C – Data Sources for Clatsop County Strategic Plan
5. Supplemental materials for Project 80: Appendix D – Data Sources for Columbia County Strategic Plan
6. Supplemental materials for Project 80: Appendix E – Clatsop County RCC Member Organizations
7. Supplemental materials for Project 80: Appendix F – Columbia County CTIN Member Organizations
8. Network and Quality Committee Charter
9. Network and Quality Committee Calendar Agenda
10. Clinical Advisory Panel Charter

Columbia Pacific CCO
Member Complaint/Feedback Form

Columbia Pacific CCO™
Part of the CareOregon Family

Your feedback is important to us. We want to fix this issue so it does not happen again. Thank you for sharing with us.

Your name: _____

Your phone number: _____

Member's name
(*if you are not the member*): _____

Member's OHP ID number and/or date of birth: _____

Please tell us what happened. (If you need more space, use the back of this form.)

_____

When did it happen?

_____

Who was involved?

_____

Please attach any documents that might help us look into the complaint.
Examples are: notices, denials of service, doctor bills or statements, letters or emails between the member and others, such as Department of Health Services, Oregon Health Authority, or Columbia Pacific CCO.

What do you want to happen now?

_____

Authorized representative information:

Name: _____ Age 18 or older: Yes ◯ No ◯

Organization: _____ Email: _____

Mailing address: _____

Phone number: _____ Signature _____

☐ Check if someone else is submitting this for you.

Submit finished form to:
CareOregon Attn: Grievance Coordinator
315 SW Fifth Ave Portland, OR 97204
Fax: 503-416-1313

Email: *customerservice@careoregon.org*

You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call 503-416-4100 or TTY 711. We accept relay calls.

Formulario de quejas/comentarios para miembros de Columbia Pacific CCO

Columbia Pacific CCO™
Part of the CareOregon Family

Sus comentarios son importantes para nosotros. Queremos solucionar este problema para que no vuelva a ocurrir. Gracias por compartir sus inquietudes con nosotros.

Su nombre:_____

Su número telefónico: _____
Nombre del miembro
(*si usted no es el miembro)*: _____

Número de identificación del OHP y/o fecha de nacimiento del miembro: _ _____

Cuéntenos qué ocurrió. (Use la parte posterior de este formulario si necesita más espacio).

_____

¿Cuándo ocurrió?

_____

¿Quiénes estuvieron involucrados?

_____

Por favor, adjunte cualquier documento que pueda ayudarnos a investigar la queja.
Los ejemplos incluyen: avisos, denegaciones de servicio, facturas médicas o declaraciones de médicos, cartas o correos electrónicos entre el miembro y otros, como el Departamento de Servicios de Salud, la Autoridad de Salud de Oregon o Columbia Pacific CCO.

¿Qué quiere que pase ahora?

_____

Información del representante autorizado:

Nombre: _____ 18 años o más: Sí ○ No ○

Organización: _____ Correo electrónico: _____

Dirección postal:_____

Número de teléfono: _____ Firma _____

☐ Marque aquí si alguien está presentando esto por usted.

Envíe el formulario completado a:
CareOregon Attn: Grievance Coordinator
315 SW Fifth Ave Portland, OR 97204
Fax: 503-416-1313

Correo electrónico: *customerservice@careoregon.org*

Puede obtener esta carta en otros idiomas, en letra grande, en braille o en el formato que usted prefiera. También puede solicitar un intérprete. Esta ayuda es gratuita. Llame al 503-416-4100 o TTY 711. Aceptamos llamadas de retransmisión.

RESILIENT CLATSOP COUNTY (RCC) STRATEGIC PLAN FRAMEWORK

Vision

A thriving Clatsop County committed to building resilience in children, families and communities

Mission

Build capacity across sectors and within the community to adopt trauma informed practices, increase protective factors and prevent and heal childhood trauma in children, families and communities

Core Values

1 Common Agenda

2 Mutually Reinforcing Activities

3 Shared Measurement

4 Commitment to Equity

STRATEGIC PRIORITIES 2021 - 2026

Problem(s)

ACEs are more prevalent in Clatsop County than nationally and Clatsop County has a higher rate of reported abuse and neglect than the state and nation. Additionally, Clatsop County has struggled with limited systemic and coordination capacity to address childhood trauma.

Strategic Priorities	Trauma Reduction	Resilience	Community Education	Supports to Families	Integration & Coordination
Goals & Metrics	Reduce ACEs/childhood trauma • % of household substance abuse • % of maternal depression Increase health and wellbeing • % increase graduation rate • % decrease truancy • % reduction juvenile crime • % of parents engaged in parenting support • % kids with a healthy attachment to at least one adult figure	Enhance children's connections to caring adults • # of parents trained • # of teachers trained • # of community members trained Improve resiliency in children and families • % change TRACEs resiliency survey children • % change TRACEs resiliency survey adults	Improve community awareness, perceptions and attitudes about childhood trauma, toxic stress, adversity and TIC • Increase education • Increase resources Increase personal skills to manage emotions and conflict • % parents better able to manage emotions & conflicts • % children better able to manage emotions and conflicts • % caregivers and teachers better able to manage emotions and conflicts	Increase social and economic supports to address financial hardship and other conditions that put families at risk for ACEs • % access to childcare • % food insecurity Increase safe, stable, nurturing relationships & environments for children and families • % improve social supports to allow parents to attend trainings and classes • % improve social supports and training for new parents	Adopt and integrate collective impact framework • Shared agenda, metrics etc. (5 conditions of collective impact) Increase adoption of trauma-informed practices by service providers/organizations • # organizations trained in TIC • # organizations with TIC plan and implementation strategies Increase understanding of how trauma, chronic stress & adversity affect brain development, individual behaviors and children's capacity to learn • # trainings in NEAR science • # individuals apply learnings from trainings • Individuals report increased awareness
STRATEGIES Activities & Partner Roles	**1** Create healthy and emotionally sustaining organizational cultures to address the impact of ACEs • Assess workforce needs and develop a plan to address those needs **2** Increase the number of trauma informed organizations and services • Offer support to adopt TIC and increase accountability **3** Intervene to lessen immediate and long-term harms of trauma • Regularly assess and plan how to address gaps across systems of care **4** Screen for ACEs/resilience in healthcare settings and others providing services in the community • Identify or create screening tools • Information training and exposure for providers on how to screen	**1** Enhance protective factors that support resilience in parents and children • Develop and/or adapt a guide for enhancing protective factors and reducing stress to strengthen community resilience • Enhance peer support (for parents/youth) • Assess best practices, what's already happening, identify gaps; based on this, develop resources	**1** Promote community education (i.e., ACEs, etc.) • Design a public awareness campaign to build understanding and awareness about linkages to ACEs, trauma and resilience (develop common language) • Align RCC (ACEs/TI) with existing community events/initiatives • Increase faith-based community involvement • Create RCC speaker's bureau (train the trainer) • Develop website • Conduct community resilience building events (start by building on existing initiatives) • Implement resiliency awareness month **2** Advocate to increase awareness of TIC • Educate and engage political representatives	**1** Strengthen social and economic supports for families • Normalize and increase parenting resources (trauma informed and resilience based parent education) and engagement • Create resource clearinghouse for parents (website as a one-stop-shop) • Gather feedback from those served • Assess, develop or link to additional parent supports (for ex ample, phone app, Facebook groups etc.) • Explore adding school-based health centers in schools • Work with youth, families and communities to identify local problems and prioritize solutions • Implement Nutrition Oregon Campaign (NOC)	**1** Increase cross-sector collaboration to align efforts and leverage funds supporting this work • Set up sector workgroups and ensure funding needs are understood, prioritized, and strategically sought • Develop a communication strategy and branding for the network • Set up project management, communication and collaboration platform to communicate and coordinate within the network • Adopt/launch "handle with care" initiative

Columbia County Childhood Trauma Informed Network (CTIN) Strategic Plan Framework

Vision

A thriving Columbia County committed to building resilience in children and families thereby improving overall community well-being

Mission

Increase cross-sector collaboration, strengthen capacity of organizations and promote community awareness to prevent and heal childhood trauma and build resilience in children and families for a healthier Columbia County

Core Values

1 Common Agenda

2 Mutually Reinforcing Activities

3 Commitment to Equity

4 Commitment to Solutions

5 Shared Measurement

STRATEGIC PRIORITIES 2021 - 2026

Problem(s)

ACEs are more prevalent in Columbia County than nationally and Columbia County has a higher rate of reported abuse and neglect than the state and nation. Additionally, Columbia County has struggled with limited systemic and coordination capacity to address childhood trauma.

Strategic Priorities	Trauma Reduction	Resilience	Community Education	Supports to Families	Integration & Coordination
Goals & Metrics	Reduce ACEs/childhood trauma • % of child abuse & neglect • % of kids in foster care Increase health and wellbeing • % children receiving dental care • % children that attended well child visits • % children with med. insurance • % graduation rates • % absenteeism	Enhance children's connections to caring adults • # of parents trained • # of teachers trained • # of community members trained Improve resiliency in children and families • % change TRACEs resiliency survey children • % change TRACEs resiliency survey adults	Increase awareness and training to community leadership around adversity and social norms that prevent violence • Improvement in community awareness, perceptions and attitudes about trauma & TIC • % of domestic violence • % of child abuse & neglect Increase parent & child/youth skills in resiliency to manage emotions & conflicts • participants report skill improvements • % school behavioral referrals	Increase social and economic supports to address financial hardship and other conditions that put families at risk for ACEs • % access to childcare • % food insecurity • % availability of transportation Increase safe, stable, nurturing relationships & environments for children and families • % improve social supports to allow parents to attend trainings and classes	Adopt and integrate collective impact framework • Shared agenda, metrics etc. (5 conditions of collective impact) Increase adoption of trauma-informed practices by service providers/ organizations • # organizations trained in TIC • # organizations with TIC plan Increase understanding of how trauma, chronic stress & adversity affect brain development, individual behaviors and children's capacity to learn • # trainings in NEAR science • Individuals report increased awareness
STRATEGIES Activities & Partner Roles	**1** Increase and integrate the number of trauma informed organizations and services • Offer support to adopt TIC and increase accountability **2** Intervene to lessen immediate and long-term harms of trauma • Home visits • Regularly assess and plan how to address gaps across systems of care • Use school-based health centers to comprehensively integrate services for families • Unify approach and protocol to look at the serve and return relationship and secure attachment • Coordinate referral process for children and youth	**1** Enhance protective factors that support resilience in parents and children • Develop and/or adapt a community protective factor framework to strengthen community resilience • Enhance peer support (for parents/youth) • Address social emotional learning in schools • Assess best practices, what's already happening, identify gaps; based on this, develop resources	**1** Promote community education (i.e., ACEs, etc.) • Community wide surveys and empathy interviews with students and families to lead to an action plan and committee • Design a public awareness campaign to build understanding and awareness about linkages to ACEs, trauma and resilience • Skill building training on ACEs and resilience (focus on 'how' of building resilience, tool box) • Develop website • Create CTIN speaker's bureau • Community resilience building events	**1** Strengthen social and economic supports for families • Normalize and increase engagement in parenting education • Work with youth, families and communities to identify local problems and prioritize solutions **2** Advocate to increase awareness of childhood trauma/TIC • Educate and engage political representatives	**1** Increase cross-sector collaboration to align efforts and leverage funds supporting this work • Set up sector workgroups and ensure funding needs are understood, prioritized, and strategically sought • Develop/identify clear and operational definition of TIC • Develop a communication strategy, branding; provide models • Learn more about what trauma and resilience looks like in particular subgroups (communities of color, etc.) • Understand how well communities of color are being served by the CTIN using disaggregated data

RCC Strategic Plan Framework Primary Data Sources for Indicators

Priority Area: Trauma Reduction **Goal 1: Reduce ACES/childhood trauma**							
Metric		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% of household substance abuse[1]		34 deaths[2]	-[3]	-[4]	-[5]	Oregon Vital Statistics Behavioral Risk Factor Surveillance System (BRFSS)	Number of overdose deaths (any opioid) in a 3-year period (2016-2018)
% of maternal depression % household mental illness		-	-	-	-	Behavioral Risk Factor Surveillance System (BRFSS)	Maternal depression includes prenatal depression, the "baby blues," post-partum depression and postpartum psychosis. This data is not available at the county level.
Priority Area: Trauma Reduction **Goal 2: Increase health and wellbeing**							
Metric		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% increase graduation rate		78.18%[6]	81.9%[7]	84.86%[8]	79.17%[9]	Oregon Department of Education (ODE)	Percentage of Clatsop County freshman that graduated within 4 years.
% absenteeism		19.17%[10]	18.48%[11]	-[12]	30%[13],[14]	Oregon Department of Education (ODE)[15]	Absenteeism is defined as "chronically absent" meaning that student missed 10% or more of their enrolled days.[16]
% reduction juvenile crime[4]		381	348	205	204	Juvenile Justice Information System	Youth referrals to juvenile justice system. [17]
% kids with a healthy attachment to at least one adult figure[6]	Grade 6 Grade 8 Grade 11	65.7% - 60.6% - 72.6% -	-	-	-	Oregon Health Authority	Clatsop County youth (grades 6, 8 and 11) who report at least one teacher or other adult at their school really cares about them.[18]
Priority Area: Support to Families **Goal 1: Increase social and economic supports to address financial hardship and other conditions that put families at risk for ACES**							
Indicator		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% access to child care[7]		17%	-	17%	-[19]	Oregon Childcare Research Partnership	Percent of children 0-5 with access to a regulated slot.[20],[21]

% food insecurity[8]	Data for overall population	12.3%	11.8%	-	-	Feeding America	Percentage of people in Clatsop County who faced food insecurity at some point in the last year.[22]
	Data for children 0 – 17	15.5%	13.6%	-	-	Feeding America	Percentage of children ages 0-17 in Clatsop County who faced food insecurity at some point in the last year.[23]

[1] Data for this indicator is not available at the county level yet. The closest currently available data aside from the overdose data is:
-Oregon Healthy Teens Survey: % of youth who report drinking one or more days in the past 30 days (data available 2019 only; 2021 data will be available later in the year?)
-BRFSS estimate: % of adults reporting binge, % of adults reporting heavy drinking, % of adults reporting marijuana use (data will be available for 2018-2021 sometime in 2022 – data is not available annually).
Clatsop Behavior Health and Columbia Memorial Hospital collect this information related to individual patients but don't have the ability to extract data from electronic medical records across their systems.
[2] Three-year rate 2016-2018.
[3] Data not yet available.
[4] Data not yet available.
[5] Data not yet available.
[6] The 2017-2018 4-Year Cohort Graduation Rate of 78.18% is based on 284 Oregon Diplomas Awarded + 17 Modified Diplomas Awarded out of an Adjusted 4-Year Cohort of 385. This is for students who began high school in the 2013-2014 school year.
[7] The 2018-2019 4-Year Cohort Graduation Rate of 81.9% is based on 309 Oregon Diplomas Awarded + 17 Modified Diplomas Awarded out of an Adjusted 4-Year Cohort of 398. This is for students who began high school in the 2014-2015 school year.
[8] The 2019-2020 4-Year Cohort Graduation Rate of 84.86% is based on 314 Graduates out of an Adjusted 4-Year Cohort of 370. This is for students who began high school in the 2015-2016 school year. Graduates include students who earned an Oregon Regular Diploma or received an Oregon Modified Diploma.
[9] The 2020-2021 4-Year Cohort Graduation Rate of 79.17% is based on 285 Graduates out of an Adjusted 4-Year Cohort of 360. This is for students who began high school in the 2016-2017 school year. Graduates include students who earned an Oregon Regular Diploma or received an Oregon Modified Diploma.
[10] In the 2017-2018 school year: Astoria SD reported 287 chronically absent students out of 1802 included students, for a chronic absenteeism rate of 15.9%. Jewell SD reported 14 chronically absent students out of 157 included students, for a chronic absenteeism rate of 8.9%. Seaside SD reported 376 chronically absent students out of 1515 included students, for a chronic absenteeism rate of 24.8%. Warrenton-Hammond SD reported 158 chronically absent students out of 943 included students, for a chronic absenteeism rate of 16.8%. Knappa SD reported 103 chronically absent students out of 474 included students, for a chronic absenteeism rate of 21.7%. Chronically absent numbers for all Clatsop County school districts: 287+14+376+158+103=938. Total included student numbers for all Clatsop County school districts: 1802+157+1515+943+474=4891. 938/4891=19.17%.
[11] In the 2018-2019 school year: Astoria SD reported 269 chronically absent students out of 1808 included students, for a chronic absenteeism rate of 14.9%. Jewell SD reported 17 chronically absent students out of 139 included students, for a chronic absenteeism rate of 12.2%. Seaside SD reported 347 chronically absent students out of 1556 included students, for a chronic absenteeism rate of 22.3%. Warrenton-Hammond SD reported 192 chronically absent students out of 973 included students, for a chronic absenteeism rate of 19.7%. Knappa SD reported 91 chronically absent students out of 480 included students, for a chronic absenteeism rate of 19%. Chronically absent numbers for all Clatsop County school districts: 269+17+347+192+91= 916. Total included student numbers for all Clatsop County school districts: 1808+139+1556+973+480=4956. 916/4956=18.48%
[12] ODE did not publish Regular Attenders/Chronically Absent data for the 2019-2020 school year.
[13] Note: Regular Attendance rates from the 2020-21 school year are not directly comparable to rates published for prior school years due to substantive changes to attendance reporting guidance in response to the COVID-19 pandemic and should not be used for comparative purposes. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx
[14] In the 2020-2021 school year: Astoria SD reported 434 chronically absent students out of 1748 included students, for a chronic absenteeism rate of 24.8%. Jewell SD reported 9 chronically absent students out of 96 included students, for a chronic absenteeism rate of 9.4%. Seaside SD reported 655 chronically absent students out of 1431 included students, for a chronic absenteeism rate of 45.8%. Warrenton-Hammond SD reported 177 chronically absent students out of 904 included students, for a chronic absenteeism rate of 19.6%. Knappa SD reported 122 chronically absent students out of 477 included students, for a chronic absenteeism rate of 25.6%. Chronically absent numbers for all Clatsop County school districts: 434+9+655+177+122=1397. Total included student numbers for all Clatsop County school districts: 1748+96+1431+904+477=4656. 1397/4656=30%.
[15] ODE did not report county level data. To tabulate county level data, we combined school district level data for all districts in Clatsop County.
[16] Excused and unexcused absences are included. https://www.oregon.gov/ode/about-us/Documents/3-2017%20Chronic%20Absenteeism%20FAQ.pdf
[17] Data is broken down by age 12 and under, 13-15, and 16+.
[18] Oregon Student Wellness Survey assesses school climate, positive youth development and the behavioral health. It is an anonymous, voluntary survey of students in grades 6, 8 and 11.
[19] Data is reported every other year.
[20] Regulated includes Certified Centers, Certified Family, Registered Family Providers, and Exempt Providers who have public slots. Access to childcare is calculated by taking the Estimated Supply of Child Care in Oregon and dividing it by the population of children in the county who fall in the age. A county is considered a child care desert if fewer than 33% of the county's children have access to a slot. https://health.oregonstate.edu/early-learners/supply. 0-13 data available: Early Care and Education Profiles: 2020 Oregon Child Care Research Partnership, Oregon State University.
[21] In 2019, ChildCare Aware found that in Clatsop County there were only 64 child care spots for every 100 children ages 0-5 with all parents in the workforce using data from the American Community Survey for number of children with all parents in the workforce and provider data submitted by the state. Overall in Oregon, ChildCare Aware found there to be 70 child care slots for every 100 children ages 0-5 with all parents in the workforce. Although very relevant, this data is not our main data source as it is not regularly collected and, as such, cannot be used for comparison across years. Child Care Aware of America.

[22] Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food-insecure households are not necessarily food insecure all the time. Food-insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. https://map.feedingamerica.org/county/2019/overall/oregon/county/clatsop

[23] Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food-insecure households are not necessarily food insecure all the time. Food-insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. https://map.feedingamerica.org/county/2019/overall/oregon/county/clatsop

CTIN Strategic Plan Framework Primary Data Sources for Indicators

Priority Area: Trauma Reduction **Goal 1: Reduce ACES/childhood trauma**							
Indicator		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% child abuse & neglect	Data for children ages 0-17	1.51%[1]	1.53%[2]	.8%[3]	-	2020 Child Welfare Data Book, DHS[4]	Child abuse/neglect defined by DHS as: mental injury, physical abuse, physical abuse in care, neglect, neglect in care, sexual abuse, sexual abuse in care, threat of harm, wrongful restraint in care, abandonment in care, financial exploitation in care, involuntary seclusion in care, verbal abuse in care.
	Data for children ages 0-5	4.0%	2.9%	-	-	OCID[5,6]	Child abuse/neglect defined by OCID as: mental injury, neglect, physical abuse, sex abuse, sex trafficking, threat of harm.
% of kids in foster care	Data for children ages 0-17	1.29%[7]	1.02%[8]	.97%[9]	-	2020 Child Welfare Data Book, DHS[10]	DHS data includes children in foster care from birth to age 21. Foster care definition includes family foster care (a family-home setting), residential treatment, trial home visits and pre-adoptive settings.
	Data for children ages 0-5	4.8%	4.1%	-	-	OCID[11,12]	
Priority Area: Trauma Reduction **Goal 2: Increase health and wellbeing**							
Indicator		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% of children receiving dental care	Data for children ages 1-17	-	17.4%	25.2%	-	APAC (All Payer, All Claims)[13]	Children who received preventive dental services, such as check-ups and dental cleanings, from a dental provider in the year.
	Data for children ages 1-5	-	12.1%	18.7%	-	APAC (All Payer, All Claims)[14]	Children who received preventive dental services, such as check-ups and dental cleanings, from a dental provider in the year.
% of children that attended well-child visits	Data for children ages 0-17	48.3%	47.2%	36.4%	-	APAC (All Payer, All Claims)[15]	Children who have received one or more well-child visits within the year.
	Data for children ages 0-5	64.8%	64.5%	57.2%	-	APAC (All Payer, All Claims)[16]	Children who have received one or more well-child visits within the year.
% children with medical insurance	Data for children ages 0-18	97.2%	96.5%	-	-	SAHIE Census Data[17]	Percentage of children 0-18 with health insurance.[18]
	Data for children ages 0-5	-	-	-	-	No data currently available	
% graduation rates		81.79%[19]	83.52%[20]	83.52%[21]	74.07%[22]	Oregon Dept of Education (ODE)	Percentage of Columbia County freshman that graduated within 4 years.
% absenteeism		21.4%[23]	20.5%[24]	- [25]	34%[26,27]	Oregon Dept of Education (ODE)[28]	Absenteeism is defined as “chronically absent” meaning the student missed 10% or more of their enrolled days.[29]

Priority Area: Community Education Goal 1: Increase awareness and training to community leadership around adversity and social norms that prevent violence							
Indicator		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% of domestic violence	Domestic violence related calls made to law enforcement agencies	-	-	556 offenses 140 arrests	-	State of Oregon Domestic Violence Annual Report	Number of cases where domestic violence was a factor for reported offenses recorded by law enforcement agencies in Columbia County.
	Domestic violence related calls made to domestic violence programs	2648 489	- 921	- 640	- 473	DHS SAFE of Columbia County	Number of domestic violence related calls to domestic violence programs as reported by DHS. Number of domestic violence calls to SAFE of Columbia County crisis hotline.
% child abuse & neglect	Data for children ages 0-17	1.51%[30]	1.53%[31]	.8%[32]	-	2020 Child Welfare Data Book, DHS[33]	Child abuse/neglect defined by DHS as: mental injury, physical abuse, physical abuse in care, neglect, neglect in care, sexual abuse, sexual abuse in care, threat of harm, wrongful restraint in care, abandonment in care, financial exploitation in care, involuntary seclusion in care, verbal abuse in care.
	Data for children ages 0-5	3.5%	-	-	-	OCID[34],[35]	Child abuse/neglect defined by OCID as: mental injury, neglect, physical abuse, sex abuse, sex trafficking, threat of harm.
Priority Area: Support to Families **Goal 1: Increase social and economic supports to address financial hardship and other conditions that put families at risk for ACES**							
Indicator		**2018**	**2019**	**2020**	**2021**	**Primary Data Source**	**Description/Definition of Indicator**
% access to childcare		18%	-	18%	-[36]	Oregon Childcare Research Partnership	Percent of children 0-5 with access to a regulated slot.[37] [38]
% food insecurity	Data for overall population	12.2%	11.4%	-	-	Feeding America	Percentage of people in Columbia County who faced food insecurity at some point in the last year. [39]
	Data for children 0 – 17	18%	15.7%	-	-	Feeding America	Percentage of children ages 0-17 in Columbia County who faced food insecurity at some point in the last year. [40]
% availability of transportation		28%	28%	28%	31.7	Oregon by the Numbers	The percentage of residents served by public transit service, measured as the unduplicated population within a .25-mile radius of a given stop operated by a transit agency.

[1] 2018 data refers to Federal Fiscal Year (FFY) 10/17-9/18. During this time period, 168 victims were identified. This is a rate of 15.1 per 1,000, which is equivalent to 1.51%.
[2] 2019 data refers to Federal Fiscal Year (FFY) 10/18-9/19. During this time period, 169 victims were identified. This is a rate of 15.3 per 1,000, which is equivalent to 1.53%.
[3] 2020 data refers to Federal Fiscal Year (FFY) 10/19-9/20. During this time period, 87 victims were identified. This is a rate of 8.0 per 1,000, which is equivalent to .8%.
[4] State total does not include Title IV-E eligible children served by Tribes. State total includes investigations of child abuse in or by a Children's Care Provider, conducted by the Office of Training, Investigations, and Safety (OTIS), formerly the Office of Adult Abuse Prevention & Investigations (OAAPI).

[5] OCID data only includes “Oregon-born” children. OCID estimates that 22% of children under 18 currently living in Oregon were born outside of Oregon. They are excluded from the dataset. Also, the total population of children includes children born in Oregon who may have moved out of state. These factors combined may lead to lower numbers than DHS even though the data is taken from DHS.
[6] Note: current OCID data use agreements extend until 2023. They hope that they will be extended for another 4-year period.
[7] Point-in-time 9/30.On this day in 2018, 141 children were in foster care. This is a rate of 12.9 per 1000, which is equivalent to 1.29%.
[8] Point-in-time 9/30.On this day in 2019, 113 children were in foster care. This is a rate of 10.2 per 1000, which is equivalent to 1.02%.
[9] Point-in-time 9/30.On this day in 2020, 106 children were in foster care. This is a rate of 9.7 per 1000, which is equivalent to .97%.
[10] State total does not include Title IV-E eligible children served by Tribes. State total includes investigations of child abuse in or by a Children’s Care Provider, conducted by the Office of Training, Investigations, and Safety (OTIS), formerly the Office of Adult Abuse Prevention & Investigations (OAAPI).
[11] OCID data only includes “Oregon-born” children. OCID estimates that 22% of children under 18 currently living in Oregon were born outside of Oregon. They are excluded from the dataset.
[12] Note: current OCID data use agreements extend until 2023. They hope that they will be extended for another 4-year period.
[13] This data source only includes dental visits billed to insurance. Visits paid for out-of-pocket are not included.
[14] This data source only includes dental visits billed to insurance. Visits paid for out-of-pocket are not included.
[15] This data source only includes medical visits billed to insurance. Visits paid for out-of-pocket are not included.
[16] This data source only includes medical visits billed to insurance. Visits paid for out-of-pocket are not included.
[17] SAHIE are model-based enhancements of the American Community Survey (ACS) estimates, created by integrating additional information from administrative records, postcensal population estimates, and decennial census data. SAHIE methodology employs statistical modeling techniques to combine this supplemental information with survey data to produce estimates that are more reliable. https://api.census.gov/data/timeseries/healthins/sahie.html
[18] SAHIE uses the American Community Survey (ACS) definition of insured. People whose only health coverage is Indian Health Service are uninsured as IHS is not considered comprehensive coverage. https://www.census.gov/programs-surveys/sahie/about/faq.html
[19] The 2017-2018 4-Year Cohort Graduation Rate of 81.79% is based on 486 Oregon Diplomas Awarded + 35 Modified Diplomas Awarded out of an Adjusted 4-Year Cohort of 637. This is for students who began high school in the 2013-2014 school year.
[20] The 2018-2019 4-Year Cohort Graduation Rate of 83.52% is based on 482 Oregon Diplomas Awarded + 40 Modified Diplomas Awarded out of an Adjusted 4-Year Cohort of 625. This is for students who began high school in the 2014-2015 school year.
[21] The 2019-2020 4-Year Cohort Graduation Rate of 83.52% is based on 512 Graduates out of an Adjusted 4-Year Cohort of 613. This is for students who began high school in the 2015-2016 school year. Graduates include students who earned an Oregon Regular Diploma or received an Oregon Modified Diploma.
[22] The 2020-2021 4-Year Cohort Graduation Rate of 74.07% is based on 417 Graduates out of an Adjusted 4-Year Cohort of 563. This is for students who began high school in the 2016-2017 school year. Graduates include students who earned an Oregon Regular Diploma or received an Oregon Modified Diploma.
[23] In the 2017-2018 school year: Scappoose SD reported 351 chronically absent students out of 2329 included students, for a chronic absenteeism rate of 15.1%. Clatskanie SD reported 223 chronically absent students out of 676 included students, for a chronic absenteeism rate of 33%. Rainier SD reported 185 chronically absent students out of 871 included students, for a chronic absenteeism rate of 21.2%. Vernonia SD reported 155 chronically absent students out of 510 included students, for a chronic absenteeism rate of 30.4%. St. Helens SD reported 629 chronically absent students out of 2813 included students, for a chronic absenteeism rate of 22.4%. Chronically absent numbers for all Columbia County school districts: 351+223+185+155+629=1543. Total included student numbers for all Columbia County school districts: 2329+676+871+510+2813=7199. 1543/7199=21.4%.
[24] In the 2018-2019 school year: Scappoose SD reported 344 chronically absent students out of 2355 included students, for a chronic absenteeism rate of 14.6%. Clatskanie SD reported 228 chronically absent students out of 676 included students, for a chronic absenteeism rate of 33.7%. Rainier SD reported 198 chronically absent students out of 856 included students, for a chronic absenteeism rate of 23.1%. Vernonia SD reported 127 chronically absent students out of 496 included students, for a chronic absenteeism rate of 25.6%. St. Helens SD reported 562 chronically absent students out of 2726 included students, for a chronic absenteeism rate of 20.6%. Chronically absent numbers for all Columbia County school districts: 344+228+198+127+562=1459. Total included student numbers for all Columbia County school districts: 2355+676+856+496+2726=7109. 1459/7109=20.5%.
[25] ODE did not publish Regular Attenders/Chronically Absent data for the 2019-2020 school year.
[26] Note: Regular Attendance rates from the 2020-21 school year are not directly comparable to rates published for prior school years due to substantive changes to attendance reporting guidance in response to the COVID-19 pandemic and should not be used for comparative purposes. https://www.oregon.gov/ode/schools-and-districts/reportcards/reportcards/Pages/Regular-Attenders-2021.aspx
[27] In the 2020-2021 school year: Scappoose SD reported 494 chronically absent students out of 2016 included students, for a chronic absenteeism rate of 24.5%. Clatskanie SD reported 187 chronically absent students out of 608 included students, for a chronic absenteeism rate of 30.8%. Rainier SD reported 290 chronically absent students out of 808 included students, for a chronic absenteeism rate of 35.9%. Vernonia SD reported 160 chronically absent students out of 511 included students, for a chronic absenteeism rate of 31.3%. St. Helens SD reported 1078 chronically absent students out of 2559 included students, for a chronic absenteeism rate of 42.1%. Chronically absent numbers for all Columbia County school districts: 494+187+290+160+1078=2209. Total included student numbers for all Columbia County school districts: 2016+608+808+511+2559=6502. 2209/6502=33.97%.
[28] ODE did not report county level data. To tabulate county level data, we combined school district level data for all districts in Columbia County.
[29] Excused and unexcused absences are included. https://www.oregon.gov/ode/about-us/Documents/3-2017%20Chronic%20Absenteeism%20FAQ.pdf
[30] 2018 data refers to Federal Fiscal Year (FFY) 10/17-9/18. During this time period, 168 victims were identified. This is a rate of 15.1 per 1,000, which is equivalent to 1.51%.
[31] 2019 data refers to Federal Fiscal Year (FFY) 10/18-9/19. During this time period, 169 victims were identified. This is a rate of 15.3 per 1,000, which is equivalent to 1.53%.
[32] 2020 data refers to Federal Fiscal Year (FFY) 10/19-9/20. During this time period, 87 victims were identified. This is a rate of 8.0 per 1,000, which is equivalent to .8%.
[33] State total does not include Title IV-E eligible children served by Tribes. State total includes investigations of child abuse in or by a Children’s Care Provider, conducted by the Office of Training, Investigations, and Safety (OTIS), formerly the Office of Adult Abuse Prevention & Investigations (OAAPI).
[34] OCID data only includes “Oregon-born” children. OCID estimates that 22% of children under 18 currently living in Oregon were born outside of Oregon. They are excluded from the dataset. Also, the total population of children includes children born in Oregon who may have moved out of state. These factors combined may lead to lower numbers than DHS even though the data is taken from DHS.
[35] Note: current OCID data use agreements extend until 2023. They hope that they will be extended for another 4-year period.
[36] Data is reported every other year.

[37] Regulated includes Certified Centers, Certified Family, Registered Family Providers, and Exempt Providers who have public slots. Access to childcare is calculated by taking the Estimated Supply of Child Care in Oregon and dividing it by the population of children in the county who fall in the age. A county is considered a child care desert if fewer than 33% of the county's children have access to a slot. https://health.oregonstate.edu/early-learners/supply. 0-13 data available: Early Care and Education Profiles: 2020 Oregon Child Care Research Partnership, Oregon State University.

[38] In 2019, ChildCare Aware found that in Columbia County there were only 63 child care spots for every 100 children ages 0-5 with all parents in the workforce using data from the American Community Survey for number of children with all parents in the workforce and provider data submitted by the state. Overall in Oregon, ChildCare Aware found there to be 70 child care slots for every 100 children ages 0-5 with all parents in the workforce. Although very relevant, this data is not our main data source as it is not regularly collected and, as such, cannot be used for comparison across years. Child Care Aware of America.

[39] Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food-insecure households are not necessarily food insecure all the time. Food-insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. https://map.feedingamerica.org/county/2019/overall/oregon/county/columbia

[40] Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Food-insecure households are not necessarily food insecure all the time. Food-insecurity may reflect a household's need to make trade-offs between important basic needs, such as housing or medical bills, and purchasing nutritionally adequate foods. https://map.feedingamerica.org/county/2019/overall/oregon/county/columbia

Appendix A

Resilient Clatsop County Member Organizations
January 2023

1. Astoria School District
2. Awakenings by the Sea
3. Clatsop CASA Program, INC.
4. Clatsop Behavioral Health
5. Clatsop Community Action
6. Clatsop County Public Health
7. Clatsop County
8. Clatsop County Sheriff's Office
9. Clatsop Juvenile Department
10. Coastal Family Yakima Farm Workers Clinic
11. Columbia Pacific CCO
12. Columbia Memorial Hospital
13. Consejo Hispano
14. Department of Human Services (District #1)
15. Helping Hands
16. Jewell School District
17. Knappa School District
18. Northwest Oregon Housing Authority
19. Northwest Regional Education Service District
20. Oregon State University Extension (Clatsop County)
21. Providence Seaside Hospital
22. Riverside Community Outreach/Every Child
23. Seaside Public Library
24. Seaside School District
25. Sunset Empire Park and Recreation District
26. The Harbor
27. Warrenton-Hammond School District

Appendix B

Columbia County Childhood Trauma Informed Network
Member Organizations
Updated January 2023

1. Adventist Health Tillamook Medical Group, Vernonia Clinic
2. Amani Center
3. CASA for Children of Multnomah, Washington and Columbia Counties
4. City of St. Helens
5. Clatskanie School District
6. Columbia Community Mental Health
7. Columbia County
8. Columbia County District Attorney's Office
9. Columbia County Public Health
10. Columbia County Treatment + Courts
11. Columbia Health Services
12. Columbia Pacific CCO
13. Columbia Pacific Food Back
14. Columbia River Fire + Rescue Scappoose Rural Fire Protection District
15. Community Action Team
16. Department of Human Services (District #1)
17. Iron Tribe Network
18. Legacy Medical Group St. Helens
19. Northwest Oregon Housing Authority
20. Northwest Regional ESD
21. Oregon Health & Science University Scappoose Clinic
22. Oregon Law Center
23. Rainier School District
24. Riverside Community Outreach/Every Child Columbia
25. SAFE of Columbia County
26. Sandee School of Horsemanship
27. Scappoose Public Library
28. Scappoose School District
29. St. Helens School District
30. Tillamook County Transportation District/NW Rides
31. United Way of Columbia County
32. Vernonia School District
33. WildFlower Play Collective
34. Youth Era

Columbia Pacific CCO
Creating Health Together
Columbia Pacific CCO (CPCCO)

Columbia Pacific CCO (CPCCO)
Network and Quality Committee Charter
November 2022

Purpose

The primary function of the Network and Quality Committee ("Committee") is to provide oversight of and assure compliance with the CCO's quality program, transformational quality strategies, network adequacy and external quality review audits. The Committee will also provide consultation to and assure adequacy of clinical quality improvement activities under the purview of CPCCO's Clinical Advisory Panel as needed.

Membership

The Committee is a Committee of the Board, in accordance with the CPCCO Operating Agreement and is comprised of three or more directors, one of whom will also serve as Chair of the Committee. Committee members serve a one-year term beginning January 1st and ending December 31st of the same year. Committee members may be re-appointed to successive terms subject to Board approval. The Executive Director will be primary staff of this Committee, with content expertise sought as necessary. The Executive Director may designate additional staff support as s/he deems appropriate to assure the Committee may discharge its functions appropriately.

Duties and Responsibilities

The Committee's specific responsibilities include:

- Review and recommend for Board approval CPCCO's annual quality plan, quality evaluation, Total Quality Strategy (TQS), QAPI, appeals and grievances and over/under utilization reports
- Review and approve the External Quality Review audit findings and corrective action plans
- Review and recommend strategies to address any deficiencies in the CPCCO provider network, including primary care, specialty, behavioral health and oral health and transportation providers, as reported in the Delivery System Network (DSN) submissions to OHA
- Update and recommend for Board approval any proposed distributions of Quality Pool funds to CPCCO clinics based on contribution to CPCCO incentive metrics performance
- Review utilization trends and variances to ensure CPCCO performs within the annual global budget
- Review and approve proposed changes in prior authorization requirements recommended by staff, to reduce or eliminate low-value services, to comply with HERC/Guidenotes, or other benefit changes mandated by the legislature or OHA

- Oversee other special projects affecting quality or network adequacy, as requested by the Board
- Review overarching CPCCO clinical quality strategies and approve investments in CAP-approved clinical strategies as applicable.

Meetings

The Committee may meet as often as may be deemed necessary or appropriate in its judgment, but at least every two months, and may conduct Committee meetings by digital and telephonic means. A majority of the members of the Committee constitutes a quorum.

Columbia Pacific CCO
www.colpachealth.org

Network & Quality Committee Calendar – 2023 (updated 1/4/2023) *Topic in blue are from 2022

Month	Date	Topic
January	Email communication	• Charter approval
February	TBD	• QA Topics: None • Other Topics: •Overview of CPCCO population data •Overview of TQS projects and plan
March	3/14/2023 9:00 – 10:00am	• QA Topics: • Other Topics: • TQS (Transformation Quality Strategy) Submission to OHA (be sure to highlight SHCN, UM)- Approval • Status Report on Improvement Plans for 2022 CMR Findings • EQR (External Quality Review) and Upcoming CMR Informational Item • DSN Report and Network Optimization Discussion (to include 2021/22 CMR Findings)
April		
May	5/9/2023 9:00 – 10:00am	• QA Topics: • Other Topics: • Grievances & Appeals, quality of care • Over/under utilization • Utilization management
June		
July	7/11/2023 9:00 – 10:00am	• QA Topics: • Other Topics: • Network Optimization/Access & Availability/DSN • Status Report on Improvement Plans for 2021 CMR Findings, 2022 CMR Update, Areas of Risk
August		
September	9/12/2023 9:00 – 10:00am	• QA Topics: • Other Topics: • Selected TQS Components (align with enterprise- TBD)
October		
November	11/14/2023 9:00 – 10:00am	• QA Topics: • Other Topics: • Grievances & Appeals • Utilization Management • CMR Findings (if available but unlikely)
December		

Columbia Pacific CCO
Clinical Advisory Panel Charter

Aim:

The Columbia Pacific CCO Clinical Advisory Panel (CAP) provides strategic leadership and direction for clinical transformation work that will help Columbia Pacific CCO achieve the Quadruple Aim.

Overarching goal:

The CAP will ensure CPCCO's clinical transformation efforts and priorities are strategically aligned with those of its constituent organizations, the CPCCO community advisory council as well as the CPCCO board, and that these efforts have the active support of clinical and executive champions at the highest organizational and community levels.

The CAP is a separate committee of the Columbia Pacific CCO Governance structure, accountable to the CCO Board of Directors.

Responsibilities:

- Establish priorities for care transformation based on data, best practice, and provider and user experience and knowledge
- Review, evaluate and/or recommend specific initiatives to meet short and long-term Quadruple Aim goals
- Set clinical targets for transformational efforts and oversee progress toward goals
- Promote sharing of best practices, development of community clinical best practice standards, and a practice culture of collaborative learning and continuous improvement
- Assure achievement of priority clinical metrics, including Core Performance and Quality Incentive Measures, and participate in the development of a monitoring system for CCO performance
- Review and recommend care models, and new incentive and payment methodologies that increasingly reward accountability for improved outcomes
- Participate in identifying opportunities to improve population health in the CCO service area (Clatsop, Columbia, and Tillamook Counties)
- Review and recommend to the CCO Board priority programs for funding by the CCO
- Understand and define integration, and identify opportunities to integrate
- Identify clinical gaps in care and access based on data in local communities
- Identify areas for clinician and staff upskilling
- Identify innovative strategies for workforce recruitment and retention
- Identify equity gaps and work on opportunities to address them

CAP Membership:

The Columbia Pacific CAP should be comprised of individuals across the clinical spectrum, with between 15-17 total members, representing the full 3-county service area of Columbia Pacific

CCO. The following are recommended disciplines for CAP membership:

- Physical Medicine Physicians (more than 1)
- Behavioral Health Professionals (more than 1)
- Social services professional (more than 1)
- At least one clinical nurse
- At least one pharmacist
- At least one dentist
- At least one Public Health professional
- At least one Emergency Department/Inpatient Leadership representative
- At least one Quality Improvement professional
- If possible: One addictions specialist

Ideally one member of the CAP is also a member of the CCO Board of Directors. Members will be selected based on direct involvement with the transformation efforts of the Columbia Pacific CCO, upon application. Applications may be submitted at any time, and will be acted upon with openings in the CAP membership. Non-members may attend open meetings of the CAP at any time, as specified below.

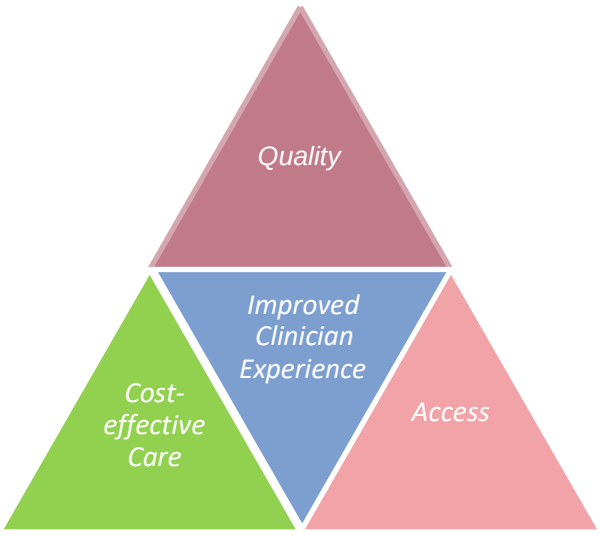
Every attempt will be made to have at least one CAP member who is also a member of the PC3 committee (whose role is to operationalize CAP directed strategy).

Meeting frequency and standards:

The CAP is staffed by both the Transformation Specialist and Medical Director.

- The CAP will have the following standards:
  - Meet every other month for 2.5 hours, with additional strategic subcommittees in between as needed.
  - The joint CAP-finance committee will continue to meet 2-3 times yearly
- Authorized to convene additional meetings
- Meetings will be open to staff from partner organizations and others by invitation
- CAP members who cannot attend a meeting should delegate their position to another person from their organization
- CPCCO staff will send updates in between CAP meetings so meetings can be largely focused on strategy and discussion

Quadruple Aim:



The CAP will use CPCCO clinical strategic buckets to help guide clinical strategy work within the CCO, specifically in the following areas:

- Quality (Metrics, Opioid work etc.)
- Access (Primary care and specialty),
- Cost-effective care (High utilizer and high-risk patients; hospital costs; utilization/referral patterns etc.)
- Integration (Within clinics with behavioral health and dental, and within the community)
- Clinic infrastructure and medical home
- Information Technology
- Recruitment and retention (provider upskilling and support, overall recruitment strategy, workforce wellness)
- Equity