# 2022 Transformation and Quality Strategy

**March 2022**

**Western Oregon Advanced Health, LLC**

**289 LaClair Street**

**Coos Bay, Oregon 97420**

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## Contents

## Section 1: Transformation and Quality Program Details

### A. **Project short title**: Medical Shelter Program

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

If continued, insert unique project ID from OHA:

### B. **Components addressed**

i. Component 1: SHCN: Non-duals Medicaid
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

### C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The 2020 Compliance Monitoring Review (CMR) of Advanced Health's ICC program by the Health Services Advisory Group (HSAG) recognized the CCO's heavy investment in staff, software solutions, program development and implementation to meet the needs of our SHCN members. Advanced Health fully met all the review elements in the Coordination and Continuity of Care standard that related to members with SHCN. The HSAG CMR report also highlighted the newly implemented Activate Care software system which organized care coordination information and care plans and ensured timeframes were met by care coordinators. Activate Care also allows those care plans and coordination information to be shared with the Member directly as well as other members of the care team outside of Advanced Health.

Last year, Advanced Health's Intensive Care Coordination (ICC) team provided services and personalized care to approximately 350 members with Special Health Care Needs (SHCN). Furthermore, Advanced Health's ICC program submitted their first care coordination activities report for the second quarter period of 2021 to the Oregon Health Authority (OHA) and is presently awaiting feedback. In 2Q of 2021, some of the numerical highlights from the report were that Advanced Health's ICC team: identified 4845 members eligible for ICC services, served 169 members, and had 17 members that declined or refused ICC. Eighty nine percent of members were screened within the required ICC time frames and 97% members in Prioritized Populations were assessed for ICC within 10 days. Since that reporting period and due to statewide CCO feedback throughout 2021, OHA instituted a yearlong ICC Learning Collaborative in 2022 to discuss program models, ICC OAR interpretations, problem solve systematic issues and build a partnership of ICC teams to better serve our SHCN members. Advanced Health is an active participant in the ICC Learning Collaborative, and staff are presenting at the March 2022 meeting.

To improve access for our SHCN members, Advanced Health has either created and/or strengthened a myriad of referral pathways and community partnerships to better meet their complex health needs. Members are identified through a variety of established CCO mechanisms and entryway points into Intensive Care Coordination services. Through Advanced Health's Customer Service department, all newly enrolled Advanced Health members are screened with a health risk assessment (HRA) and given the opportunity to self-identify special health care needs for referral to intensive care coordination services. Also, Members can self-refer by calling Customer Service or be referred by primary care

homes, LTSS case managers, health care professionals, social service agencies, family members, and/or caregivers. It is always Advanced Health's preference to identify eligible Members for Intensive Care Coordination at the time of enrollment through screening protocols, through annual re-assessment or Member request, rather than through triggering events such as a new hospital admission or recent homelessness. Nonetheless, triggering events also serve to create occasions for entry to Intensive Care Coordination. It should be noted that the greatest demand for ICC services originated from our community partners due to the pandemic impact on healthcare system, increased community awareness of the availability services staff and/or members themselves.

Each ICC member is assigned a Care Coordinator (such as a Traditional Health Worker or Registered Nurse) as a single and consistent point of contact. Member's assigned coordinator assists the member in identifying and resolving healthcare barriers from assessment information (PRAPARE), collaboration from the member, and additional information from their care team participants in case conferences such at Bay Hospital, individualized complex coordination meetings and/or collaborative problem-solving month meetings with Aging and People with Disabilities.

SHCN Member's care plans are built by Advanced Health care coordinators in Activate Care with an emphasis on using a comprehensive and wholistic approach. ICC teams members are encouraged to collaborate on plans depending upon the complex needs of the member such as medical, behavioral, and/or social. Care plans incorporate interdisciplinary goals, evidence of member participation, distinct roles for care team members and clear tracking of ICC time frames to help remind Advanced Health coordinators of the necessary tasks to complete enrollment, intake, and healthcare specific goals. Current length of care on average in our program varies from short term to long term usually spanning a time frame of 3 to 18 months. If a healthcare or SDOH barrier is identified by the coordinator that requires a flex fund (flexible Health-Related Services spending) intervention, Advanced Health has developed an internal ICC flex fund process to reduce the barriers frequently encountered by our SHCN members.

For members with SHCN needing access to a specialist, determined through a comprehensive assessment by either the ICC Director and/or ICC program manager and noted to have ongoing special conditions requiring a course of treatment or regular care monitoring, Advanced Health will allow direct access to a specialist, at no cost to the member. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist without an authorization. The referring provider should also notify Advanced Health of the referral by submitting the Physician Authorization Form, found on Advanced Health's website, marking the SHCN Box at the top of the form and providing the name and contact information of the specialist. This will allow the creation of an authorization number to be provided to the specialist for billing purposes. This authorization will include pre-approved visits (i.e.6 visits in 6 months) allowing the member to establish with specialist and receive care.

Advanced Health's ICC team has developed strong and valuable relationships internally and externally with medical, behavioral, and social service professionals to greatly improve coordination of care and discharge planning for SHCN members. ICC staff are consistently present at weekly hospital complex case meetings, Coos and Curry behavioral health ICC sub-contractor meetings and built a new monthly partnership with DHS APD case management through an updated memorandum of understanding. Additional contracts were awarded to community-based organizations serving unhoused populations, such as Brookings CORE and Nancy Devereux Center, to expand the reach of ICC services and provide additional support to one of the most vulnerable SHCN population groups. Through these improved collaborations, Advanced Health invested additional funds into the Coal Bank Village (pallet sheltered community) operated by the Nancy Devereux center for the purposes of medical sheltering. Currently, the Advanced Health ICC team meets weekly with the Nancy Devereux staff to monitor the medial sheltering program which is described in detail in the subsequent sections of this report below.

The Devereux Center offers support systems and advocacy for the homeless, those suffering from mental illness, and veterans. They serve an average of 80 people a day. Also known as the Nancy Devereux Center, they are a 501(C)3 tax-

exempt non-profit organization founded in 1979. The Center is a day facility that is open from 9 am to 2 pm every week on Monday, Tuesday, Wednesday, and Friday.

Coal Bank Village has 19 Pallet Homes available and is designed to provide safe, warm and comfortable housing to those beginning their journey towards a brighter future. Residents share access to a full kitchen area as well as a covered recreation area containing comfortable lounging areas and a T.V.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Due to the strain of the pandemic response on existing Bay Area Hospital (BAH) discharge staff and community resources, the need for available medical shelter for SHCN members was evident to Advanced Health's ICC program in 2021. Existing strong relationships between Advanced Health's ICC team and the Nancy Devereaux Center, enhanced our abilities to provide direct access to unhoused members with complex medical and behavioral health needs in need of medical sheltering and additional housing and other social resources. The overarching goal of this program is to improve healthcare outcomes for this SHCN population by hosting regular care coordination meetings, monitoring member's health status, and work towards a robust discharge plan to longer term housing.

The need for availability of medical shelter is complex, with a multifactorial basis. As the rate of homelessness increases, resources have been strained. In the experience of the Advanced Health ICC team, and through frequent interactions with area hospitals and clinics, as well as social and behavioral health service providers, those with SHCN who are also experiencing houselessness seem to fall into three categories: first, the medically fragile who are newly homeless and have not been able to navigate meeting their own needs; second, the medically complex homeless who have been without a home for a longer timeframe and have declining health; and third, those with chronic health conditions, who have struggled with homelessness, and have an increased rate of alcohol and substance abuse, typically as a means of coping.

As Covid surges have strained resources and agency staff, the availability of services has become more limited. A discharge referral to wound care may take 1-3 weeks for an initial appointment. PCP offices are unable to meet the need for close follow-up post hospital discharge, due to offices being inundated with needs. Outpatient infusion, cancer treatment, dialysis providers, and home health all have limited capacity to accept new referrals. Lack of availability of needed treatment, in some cases, has had a direct correlation with loss of ability to maintain housing. Area Skilled Nursing agencies, Long-term care facilities, and residential treatment centers have had a decreased capacity, resulting in more complex medical needs post discharge.

As the medically complex or compromised homeless have struggled with declining health, the rate and length of hospitalization has increased. ICC has seen a steady increase in five population groups, over the last 6-8 months, all of whom need discharge shelter:

1. Older individuals, post CVA, homeless, and not meeting criteria for APD services.
2. Homeless individuals struggling with liver or renal disease, with either a relapse on alcohol or a worsening of alcohol or substance abuse, with recurrent episodes of acute liver related crisis (ascites, liver failure, encephalopathy) or acute renal failure.
3. Homeless individuals with cellulitis, of varying origins.
4. Homeless individuals who have been unable to manage diabetic needs, who are now experiencing non-healing lower extremity ulcers and, in some cases, amputations.
5. Homeless individuals with respiratory illness requiring post hospital DME equipment (i.e., oxygen, C-PAP, Bi-PAP) which requires access to electricity

The overall availability of housing has diminished over the past 16 months. Those who are newly homeless and who have limited resources, are unable to find affordable housing. This has resulted in:

- All resources the individual has going to motel expenses, until those resources are exhausted. Those in this category have been, in ICC's experience, older individuals post CVA or with diabetic complications.
- Individuals living in vehicles for longer periods of time, with resources diminishing. Those in this category, again in ICC's experience, have been those with cellulitis or diabetic complications.
- Decreased availability of motel rooms in the area, which has driven up the cost for motel stays.

The end point in this is that those who are medically complex, fragile, or compromised, who potentially could have found housing pre-covid, end up on the streets and then hospitalized for a medical crisis.

## E. **Brief narrative description**:

In the 4th quarter of 2021, the Advanced Health ICC team created a new pathway between hospital nursing case managers and the Devereaux Center's Coal Bank Village to medically shelter four Advanced Health members. Each member was housed for a period of a week and up to four weeks for medical stabilization, recovery, and transition to longer term stable housing. A tracking sheet was also created to gather necessary information such as entry date, exit date, total days housed, member name, Medicaid ID, referral source, medical need, outcome and ICC program status. Advanced Health will continue to utilize this tracking sheet to document our progress with this new program. Currently, there are two medical shelters, a member waitlist and plans to expand to additional shelters in 2022. Advanced Health ICC staff have a standing weekly meeting with Devereux Center staff to review cases and coordinate services.

The Medical Shelters at Coal Bank Village are for the purpose of providing a safe environment for medical respite. This may include recovery time post-hospital discharge, pre-operative or pre-procedure preparation, medical needs, and motel diversion.

Benefits of this new Advanced Health program are that SHCN Members with complex medical needs and experiencing houselessness post discharge will have a safe and clean environment to facilitate healing. Coal Bank Village has 24-hour security which provides a safety net for medically complex individuals. The Village is a clean and sober environment, which can promote abstinence in those who have medical needs and are struggling with SUD concerns. Devereux Center case managers, along with ICC care coordinators, will be able to closely follow Members, to ensure medical follow-up, wound care, and other needs are met. The Devereux staff can remind Members to take medications, which is often forgotten when homeless and/or unsheltered. Members have access to electricity and a kitchen space, to assist with meeting nutritional needs. The community environment can provide for social needs and decrease stress levels, which are factors in healing. Clean healing environment, additional healing time in a sheltered environment, improved access to aftercare and needed services, and the safety built in with 24-hour staff will likely result in decreased re-hospitalization rates, improved outcomes, and improved health. Members may be able to access additional community resources and services, which has the potential to provide for housing needs, behavioral health needs, SUD needs, nutritional needs, and more. Members may be able to transition from a medical shelter to one of the Devereux shelters and continue forward with moving out of homelessness.

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

**Activity 1 description:** Meet the complex medical and social needs of SHCN members experiencing homelessness in order to improve health and provide access to more stable housing resources. Monitor improved health outcomes by a corresponding reduced need to emergency department visits or hospital inpatient stays. Monitor improved access to housing resources by reducing the need for motel stays.

☐ Short term or ☒ Long term

| **Monitoring measure 1.1** | Diversion from the emergency room: monitoring the average number of visits per member for 3 months following participation in medical shelter program. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 5.3 ED visits/member on average in 3 months prior to entering program (Q4 2021) | 1.2 ED visits/member on average in 3 months after entering program | 3/2022 | 1 ED visit/member on average in 3 months after entering program | 12/2022 |
| **Monitoring measure 1.2** | Diversion from hospital inpatient stay: monitoring the average number of inpatient days per member for 3 months following participation in the medical shelter program | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 12 inpatient days/ member on average in 3 months prior to entering program (Q4 2021) | 2.5 inpatient days/ member on average in 3 months after entering program | 3/2022 | 2.5 inpatient days/ member on average in 3 months after entering program | 12/2022 |
| **Monitoring measure 1.3** | Motel diversions: monitoring the percentage of members participating in the medical shelter program who would have otherwise needed a motel stay for shelter. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 80% (Q4 2021) | 85% | 12/2022 | 85% | 12/2022 |

**Activity 2 description**: Monitor utilization of the medical shelter beds to ensure resources are used effectively with two goals in mind. First, maintain a high rate of occupancy to ensure available resources of the program are being used by SHCN members. Second, maintain an average length of stay of approximately two and a half weeks to ensure the resources are available to as many SHCN members as possible.

☒ Short term or ☐ Long term

| **Monitoring measure 2.1** | Percentage of days occupied per year – note target is set lower than the rate calculated for the first month and a half of the program in late 2021 as maintaining an occupancy rate of 97% is unlikely to be sustainable. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 87/90 days = 97% occupancy in November and December 2021. | 85% | 3/2022 | 85% | 12/2022 |
| **Monitoring measure 2.1** | Average length of stay (LOS) | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 19 days (Q4 2021) | 19 days | 3/2022 | 19 days | 12/2022 |

## A. **Project short title**: Provider Network Training

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

If continued, insert unique project ID from OHA:

## B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? 2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

## C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Efforts for planning the provider network training program ramped up in 2019 when a more formal plan was desired by Advanced Health leadership. In order to advance health equity and implement the CLAS Standards in regard to the provider network, it was necessary to ensure that providers and their staff had a common understanding and used common language when it came to health equity and cultural awareness.

In previous years, Advanced Health hosted and sponsored several trainings in the Coos and Curry communities related to health equity and culturally responsive services. Advanced Health brought in nationally recognized trainers to the area to provide staff, provider network and their staff, and community training on the Culture of Poverty, and sponsored local Poverty Simulations. Advanced Health sponsored training on Adverse Childhood Experiences (ACES) so that our region could "grow their own" ACES trainers and ensure the local availability of ongoing ACES trainings. See the South Coast Together project in this TQS report for more details on Advanced Health's ongoing work around ACE training and building resilience. Advanced Health brought in internationally recognized trainers to train on facilitating community conversations café style to promote and build Resilience. Advanced Health hosted trainings on Health Literacy and Culturally Linguistically Appropriate Services (CLAS) for network providers, their staff, Advanced Health staff, community partner's staff, and the Coos and Curry communities.

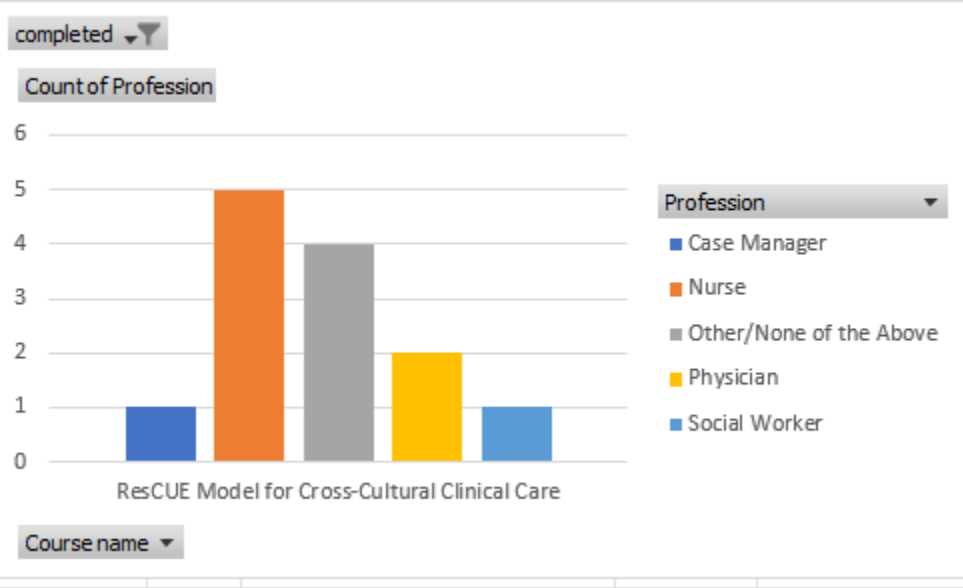
In 2019, Advanced Health contributed to the planning and was a fiscal sponsor to the 1st Annual South Coast Diversity Conference. We encouraged our staff, network providers, and Community Advisory Council (CAC) members to attend. Training topics included: Pronouns, Tribal History, Microaggressions in the Workplace, Behavioral Health, and a keynote from Alberto Mareno with an overview of equity programs and work done in Oregon.

In 2020, the South Coast Diversity Conference was planned for April and Advanced Health sponsored and planned to administer a livestream track that would be relayed to provider network clinics and hospitals as well as in conference rooms at Advanced Health and several community partners. Topics of training included: Unpacking Privilege, Implicit Bias, Supporting People with Differences, and Cultivating Empathy. Unfortunately, due to the COVID 19 emergency response in March and April of 2020 and large group restrictions, the conference was cancelled.

## OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

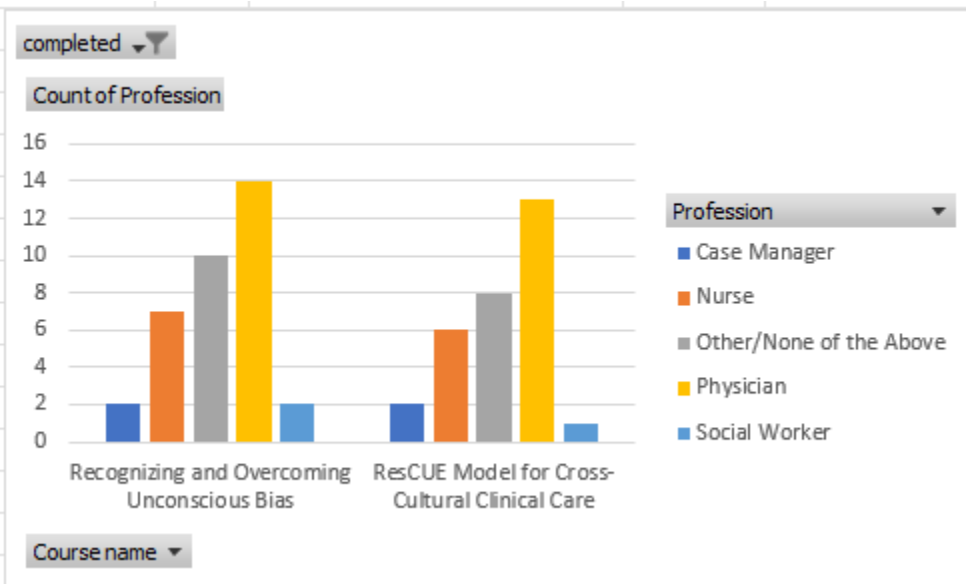
In 2020, Advanced Health offered an online, self-guided learning module: ResCUE Model for Cross-Cultural Clinical Care, to network providers and their staff. This training was chosen from OHA's menu of approved Cultural Competence & Continuing Education trainings, listed on the website of the OHA Office of Equity and Inclusion. The learning module was offered with continuing education credit attached, and thirteen users completed the training in 2020. Despite frequent communication and advertisements to network providers, clinical- and HR/business office staff of the training opportunity, local COVID-19 pandemic response efforts affected the bandwidth of the provider network during 2020, thus affecting the low turnout of training completion.

**2020**




Advanced Health's 2021 provider network training plan was offered to all providers and their staff on an ongoing basis throughout the year. The format was two options to attend an online, self-guided training module: ResCUE Model for Cross-cultural Clinical Care and Recognizing and Overcoming Unconscious Bias. The trainings were offered at no charge to the attendee or healthcare facility, and continuing education credits were available.

**2021**

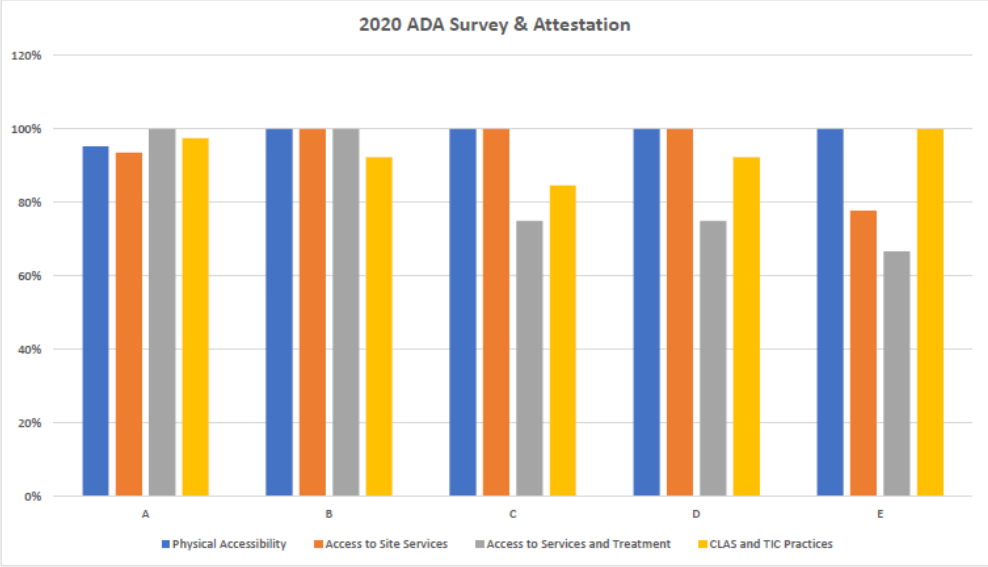



Advanced Health planned on restrictions being lifted and being able to plan and schedule in-person trainings. In-person trainings are a preferred method of training delivery to increase attendance rates and audience interest. Unfortunately, due to COVID in-person restrictions remained into 2021 and continued in 2022.

Advanced Health has always provided Language Line interpreter services to our membership and provider offices. We also provided healthcare interpreters. However, in 2018 we decided to develop a more formal Healthcare Interpreter Program, to include network provider training and education. This would ensure that our membership and provider network could access telephonic and in-person interpretation services, as well as understood the value interpreter services bring to quality healthcare. The CDC Plain Language Thesaurus is also provided to staff and providers.

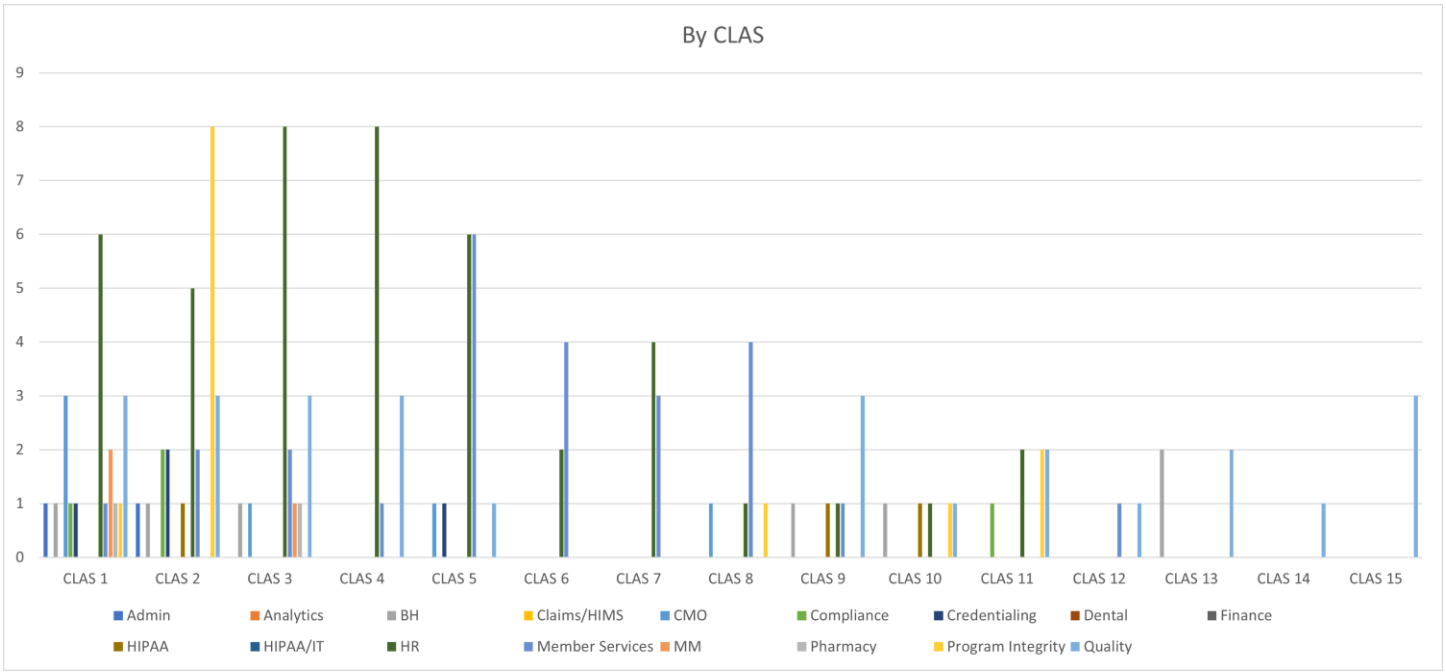
In an effort to promote and provide education on the availability of language access services, outreach materials have been developed and are distributed via the Advanced Health website, mailed, or provided during network provider training sessions. Advanced Health has a provider-facing brochure that was developed in 2019 to educate the provider network about the availability and value of in-person, OHA-qualified Spanish language interpreter services from Advanced Health staff. Advanced Health includes healthcare interpreter services information in new provider orientations. In 2021, twenty-eight providers attended the new provider orientation sessions.

Advanced Health conducts provider network participant audits which include an ADA Attestation and Survey. The goal of this survey is to ensure that the Provider Network is providing effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs, in accordance with Title III of ADA, CLAS Standards, and all other applicable rules and regulations. While this is not a formal training method, the ADA Survey supports establishing and maintaining a common language for CLAS Standards, which can promote further exploration of the information by network providers and their staff. It also affords Advanced Health an opportunity to ensure network providers correct any deficiencies found during the audits.




Results from Advanced Health's 2020 Health Equity organizational self-assessment recognized strengths of current and past efforts to raise awareness of CLAS Standards and implement them throughout the organization and the provider network, as well as the need for additional work and to apply the standards more broadly and clearly through policy and procedure.

In 2021, Advanced Health department managers and directors participated in a department-level review of CLAS Standards currently implemented through policies, procedures, processes, and practices. This department-level assessment is used as a baseline and will inform Advanced Health's broader CLAS implementation plan. The results of that review are given below.




Also in 2021, executive and HR staff adapted a CLAS organizational assessment tool from the Massachusetts Department of Public Health for use by Advanced Health to give an organization-level overview of the implementation status of CLAS Standards. The questionnaire is designed to help organizations identify their own challenges and goals, and to guide the

creation of a work plan to achieve those goals using the CLAS Standards as a framework. From the results of this review, and the other data provided above, Advanced Health has prioritized CLAS training and incorporating more CLAS Standards in written policies and procedures.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Implementing the Culturally and Linguistically Appropriate Services (CLAS) Standard as an organization is a priority for Advanced Health. Review of CLAS Standards and initiatives to implement CLAS Standards have always been part of the annual Transformation and Quality Strategy, Delivery System Network analysis and planning, Grievance and Appeal data monitoring, and other organizational processes. Efforts have been made to further implement CLAS Standards into the Provider Network Training Plan.

Advanced Health adopted and uses the definition of cultural competence in OAR 943-090-0010:

> *"Cultural competence" means a life-long process of examining values and beliefs and developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities.*
>
> *(a) Cultural competence applies to all patients.*
>
> *(b) Culturally competent providers do not make assumptions on the basis of an individual's actual or perceived abilities, disabilities or traits whether inherent, genetic or developmental including: race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, gender transition status, level of formal education, physical or mental disability, medical condition or any consideration recognized under federal, state and local law.*

This definition paired with the CLAS Standards has guided Advanced Health's Provider Network Training Plan.

In December 2020, Advanced Health conducted a training needs' assessment for the provider network which showed us the training needs. A training program evaluation would highlight what changes we need to make to the program for the next year. Learning outcomes include increasing awareness and use of common language, increase percent of highly trained workforce members, increase engagement with CCO health equity work, and continued use of CLAS Standards as a framework for culturally responsive care.

## TRAINING NEEDS ANALYSIS / ASSESSMENT TEMPLATE

Employees, Board of Directors, CAC Members, and Provider Network | Health Equity Plan | ASSESSMENT COMPLETED: 12/2020 | DATE COMPLETED:

| Subject Area | Training Requirement/Measurement (How was training identified) | Training Methods / Action Plan | Training Frequency |
|---|---|---|---|
| Cultural Competent Care | Health Equity Plan | Online self-guided module \| In-person/virtual \| Conference | See matrix for schedule and by group |
| Implicit Bias | Health Equity Plan | Online self-guided module \| In-person/virtual \| Conference | See matrix for schedule and by group |
| Civil Rights and Non-Discrimination Laws | Health Equity Plan | Online self-guided module \| In-person/virtual \| Conference | See matrix for schedule and by group |
| Social/Cultural Diversity | Health Equity Plan | Online self-guided module \| In-person/virtual \| Conference | See matrix for schedule and by group |

Our efforts to develop a defined network provider training program to roll out in CY2021 resulted in a program offering multi-modalities and an array of training topics for the provider network and their staff. The training plan which will be conducted over the course of the five year CCO contract will include: Cultural Competent Care, Implicit Bias, Civil Rights and Non-Discrimination Laws, Social/Cultural Diversity, Universal Access/Accessibility in Addition to ADA, Language Access and Use of Interpreters, Health Literacy, Use of Traditional Health Worker Model, Adverse Childhood Experiences, Cultural Barriers and Systemic Oppression, Social Determinants of Health, Trauma Informed Care, Culturally Linguistically Appropriate Services (CLAS) Standards, Use of Data to Advance Health Equity (REAL-D), ACA 1557. Much of the content and trainings within Advanced Health's provider network training program align and meet the OHA cultural competency continuing education criteria.

Advanced Health's Clinical Advisory Panel (CAP) viewed A Class About CLAS training and education video in August 2021. Six physicians and a total of ten attendees were present. Proposals to teach the CLAS Standards to provider network staff, specifically mental health staff, and to teach other CLAS-specific objectives were both discussed at the August CAP meeting.

Advanced Health has provided CLAS training, including lecture and workshops, to its provider network, board of directors, staff, committee members, and community partners, and has committed to providing CLAS training via multiple modalities for our region on a regular basis. Providing space for education to ensure that common knowledge and common language could be the foundation of our framework was and is vital to the successful implementation of CLAS Standards.

Sustainability is an area of much focus and planning efforts. We want the provider network to have an ongoing commitment to health equity. Advanced Health's strategic plan focuses on health equity, and we have designated staff to oversee the health equity initiatives. Our trained providers and advisory committees help implement health equity activities and our CACs work collaboratively with other equity-focused groups in the area. Advanced Health is committed to healthcare interpreter training and supports the ongoing education and employment of traditional health workers. Advanced Health has allocated funds to the provider network training plan and its health equity work.

Throughout the provider network, Advanced Health sponsors, promotes, and offers technical assistance in monitoring culturally and linguistically appropriate trainings for both providers and their staff. Some of the training opportunities Advanced Health has sponsored locally include topics such as CLAS, health literacy, the culture of poverty, recognizing and honoring diversity, trauma-informed practices, implicit bias, cultural awareness, and the impacts of adverse childhood experiences. Details of current provider training offerings can be found on the Advanced Health website and are communicated to the provider network through the provider newsletter, the Interagency Quality Committee, announcements to provider offices' HR staff, office manager, and quality staff, and through Advanced Health provider relations services. Many of the trainings and workshops related to equity and inclusion or adverse childhood experiences are also available to non-clinical community partners.

E. **Brief narrative description**:

Advanced Health will maintain the current provider communication plan and training opportunities of online, virtual training opportunities, and expanded different learning objectives. The local, annual Diversity Conference planning process is underway for 2022, and Advanced Health plans to provide financial support and will also promote the conference through our communication plan to encourage attendance by staff, providers, provider network staff, CAC and board members. In addition, in late 2021 Advanced Health staff began work to develop a written Provider Network Training policy and procedure. This policy and procedure will be implemented and monitored in 2022.

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Advanced Health Provider Communications and training plan matrix included providing training and education to the provider network and provider network staff in culturally and linguistically appropriate services, policies, and practices upon new entry to the provider network and ongoing, monitoring attendance and completion rates.

| Training Topic | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Advanced Health employees | Board of Directors | Community Advisory Council (CAC) Members | Provider Network |
|---|---|---|---|---|---|---|---|---|---|---|
| Cultural Competent Care | x | x | x | x | x | x | 2021<br>2022 | | | 2021<br>2022 |
| Implicit Bias | | | | | | | 2021<br>2022 | | | 2021 |
| Civil Rights and Non-Discrimination Laws | | | | | | | | | | |
| Social/Cultural Diversity | | | | | | | 2021<br>2022 | | | 2022 |
| Universal Access/Accessibility in addition to ADA | | | | | | | | | | |
| Language Access/Use of Interpreters | | | | | | | | | | 2021<br>2022 |
| Health Literacy | | | | | | | | | | |
| Use of Traditional Health Worker (THW) Model | | | | | | | | | | |
| Adverse Childhood Experiences | | | | | | | | | | 2022 |
| Cultural Barriers and Systemic Opression | | | | | | | | | | |
| SDoH | | | | | | | | | | |
| Trauma-Informed Care | | | | | | | | | | 2022 |
| CLAS Standards | | | | | | | | | | 2022 |
| Use of data to advance health equity (REAL+D) | | | | | | | | | | |
| ACA 1557 | | | | | | | | | | |

Measurements for meeting goals included measuring attendance and completion rates, a communication plan for trainings opportunities, and monitoring Advanced Health's technical support provided to provider network.

Advanced Health has implemented a communication plan with the provider network to share information about Advanced Health offered or sponsored training opportunities throughout the year. Training announcements went out each quarter via the following methods: email communications, virtual provider network trainings, and provider network newsletters. Providers, their staff, including HR/Business Managers and Quality staff, were provided a tracking spreadsheet template to track trainings. This ensures key staff in the organization have up to date information to share as needed during provider network communications.


Advanced Health supports a strong learning culture within the Advanced Health Provider Network. In an effort to offer providers and their staff valuable, informative, and culturally responsive training opportunities, a training plan and timeline has been developed and implemented in a curated and organized manner. The company allocates resources for training plans: cost, time, and effective use of internal and external expertise are allocated appropriately and within budget constraints. All training opportunities are developed, managed, and delivered with due regard to fairness and equity, and without discrimination.

It is important that Advanced Health offer trainings in multiple modalities, using appropriate accommodations and interpreter services. We know that some trainings are best received in a live setting, while others could be offered online.

To address attendance challenges, Advanced Health has offered multiple date and time options for attendees. Advanced Health has also offered trainings that have continuing education credits attached to encourage providers and clinical or other certified staff to attend.

These interventions primarily address CLAS Standards 2 and 4:

> CLAS Standard 2: Advanced and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
>
> CLAS Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Advanced Health will continue to identify and offer training opportunities to meet the cultural competency training objectives by following the activities and improvement methods detailed in the section below.

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

**Activity 1 description**: Online Self-guided Learning Modules

☒ Short term or ☐ Long term

| **Monitoring measure 1.1** | Attendance | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| The completion rate was 46 attendees in 2021, up from 13 in 2020. Training objectives offered include ResCUE Model for Cross-cultural Clinical Care and Recognizing and Overcoming Unconscious Bias. | In 2022, offer the following training objectives: Cross-Cultural Care in Mental Health & Depression and Working w/Specific Populations: Hispanic/Latino | 12/2022 | Planned target of 80 attendees across both training courses/objectives. | 12/2022 |
| **Monitoring measure 1.2** | Communication Plan | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| At least quarterly communication to network providers, HR/business office staff, and Quality staff at provider offices. | Communication planned for first 2022 network provider newsletter, and HR/business office staff, Quality staff at provider offices, and CME coordinator at local hospital. | 03/2022 | Quarterly communication plan | 12/2022 |

**Activity 2 description**: Diversity Conference Sponsorship

☐ Short term or ☒ Long term

| **Monitoring measure 2.1** | Fiscal Sponsorship | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Previous sponsor of past local Diversity Conferences | Sponsor 2022 local Diversity Conference | 03/31/2022 | Sponsor 2023 local Diversity Conference | 03/31/2023 |
| **Monitoring measure 2.2** | Attendance | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Advanced Health tracks employee attendance for Diversity Conference | Continue attendance tracking | 04/2022 date of conference | Continue attendance tracking for Diversity Conference | 04/2023 |

**Activity 3 description** : Network Provider Training and Education Plan Policies and Procedures

☐ Short term or ☒ Long term

| **Monitoring measure 3.1** | Implementation | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |

| | | | | |
|---|---|---|---|---|
| Practices in place to implement a training plan, but no written policies and procedures. | Documented practices, and policy and procedure in place for the Network Provider Training and Education Plan | 01/2022 | Monitoring and adhering to the policies and procedures set forth in the Network Provider Training and Education Plan | 01/2022 |
| **Monitoring measure 3.2** | Monitoring of Adherence | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Practices in place to implement a training plan, but no written policies and procedures for monitoring. | Quarterly evaluation of adherence to the policies and procedures set forth in the Network Provider Training and Education Plan | 12/2022 | Monitoring and adhering to the policies and procedures set forth in the Network Provider Training and Education Plan | 12/2022 |

## A. **Project short title**: South Coast Together – ACEs Training and Prevention

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

If continued, insert unique project ID from OHA: 40

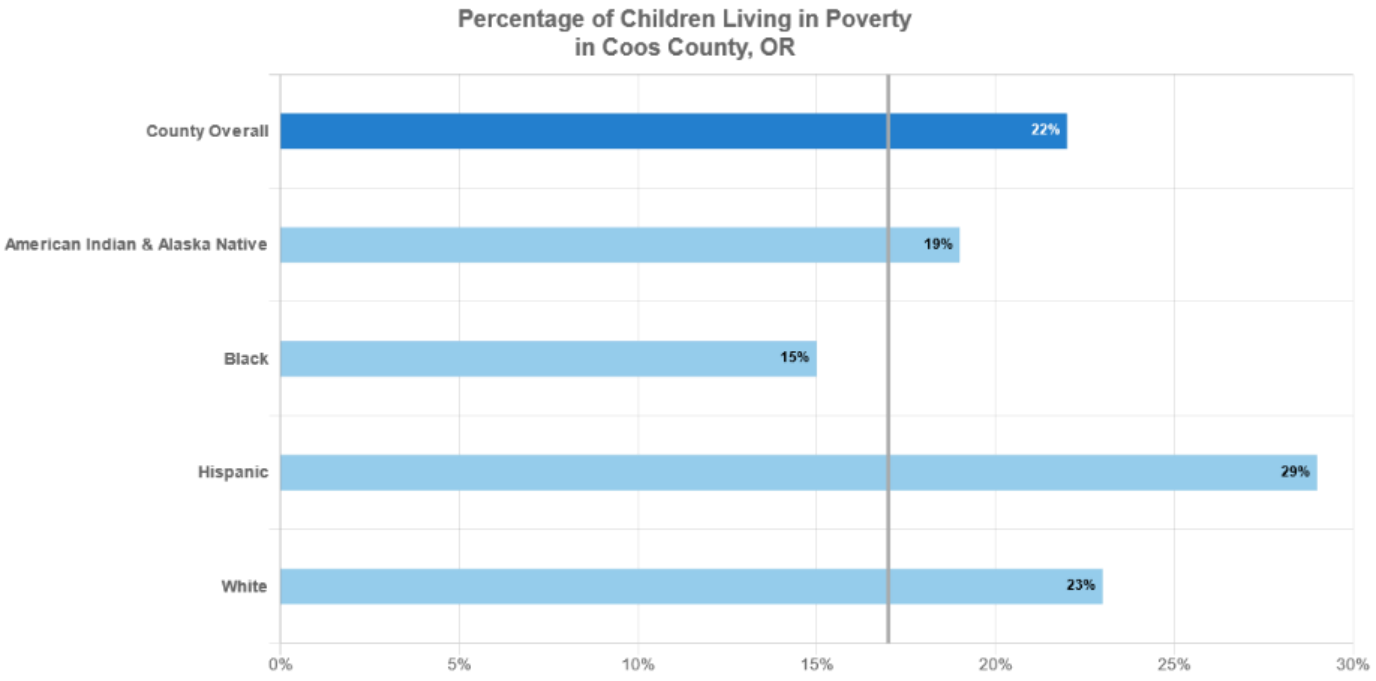
## B. **Components addressed**

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

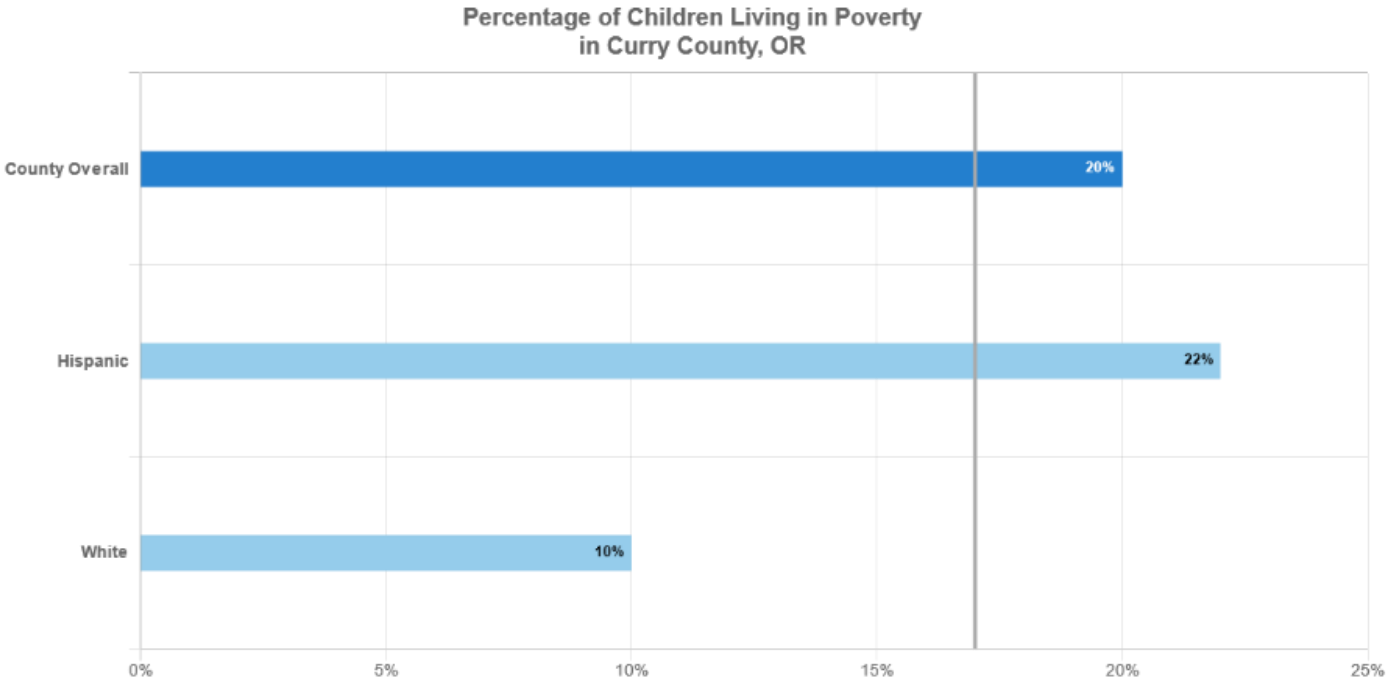
## C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The findings from the Adverse Childhood Experiences (ACE) study are the largest public health discovery of our time. The evidence linking childhood traumas to adverse health outcomes makes it clear that finding ways to mitigate and prevent trauma, as well as promoting resiliency for people impacted by ACEs, is key to improving the health of the community. The Master Training program and Self-Healing Communities Initiative from ACE Interface have been adopted in other states and are showing early evidence of improved outcomes.

Advanced Health's service area of Coos and Curry counties have some indicators of higher rates of traumas. The 2021 percentage of children in poverty in Coos County was 22% and Curry County was 20% with an Oregon statewide rate of 16%. A breakout of ethnicity in Coos County shows rates for Hispanic 29%, and White 23% are higher than the county average, while American Indian and Alaskan Native 19% are above the national average of 17%. (Source: https://www.countyhealthrankings.org/reports/children-living-in-poverty)



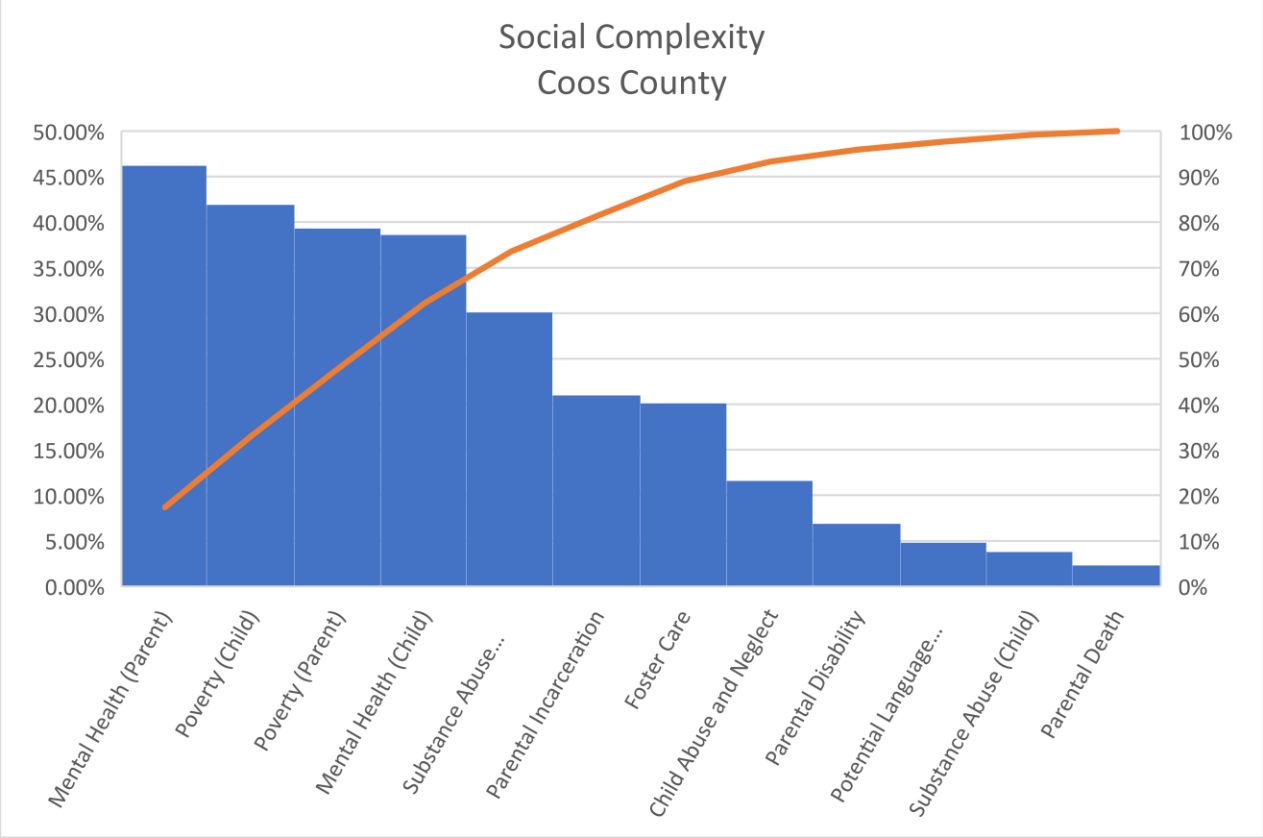

Curry County shows a slightly different story, 22% of all Hispanic children living in poverty, above the county average of 20%, while white Children are below the county average at 10%. (Source: https://www.countyhealthrankings.org/reports/children-living-in-poverty)



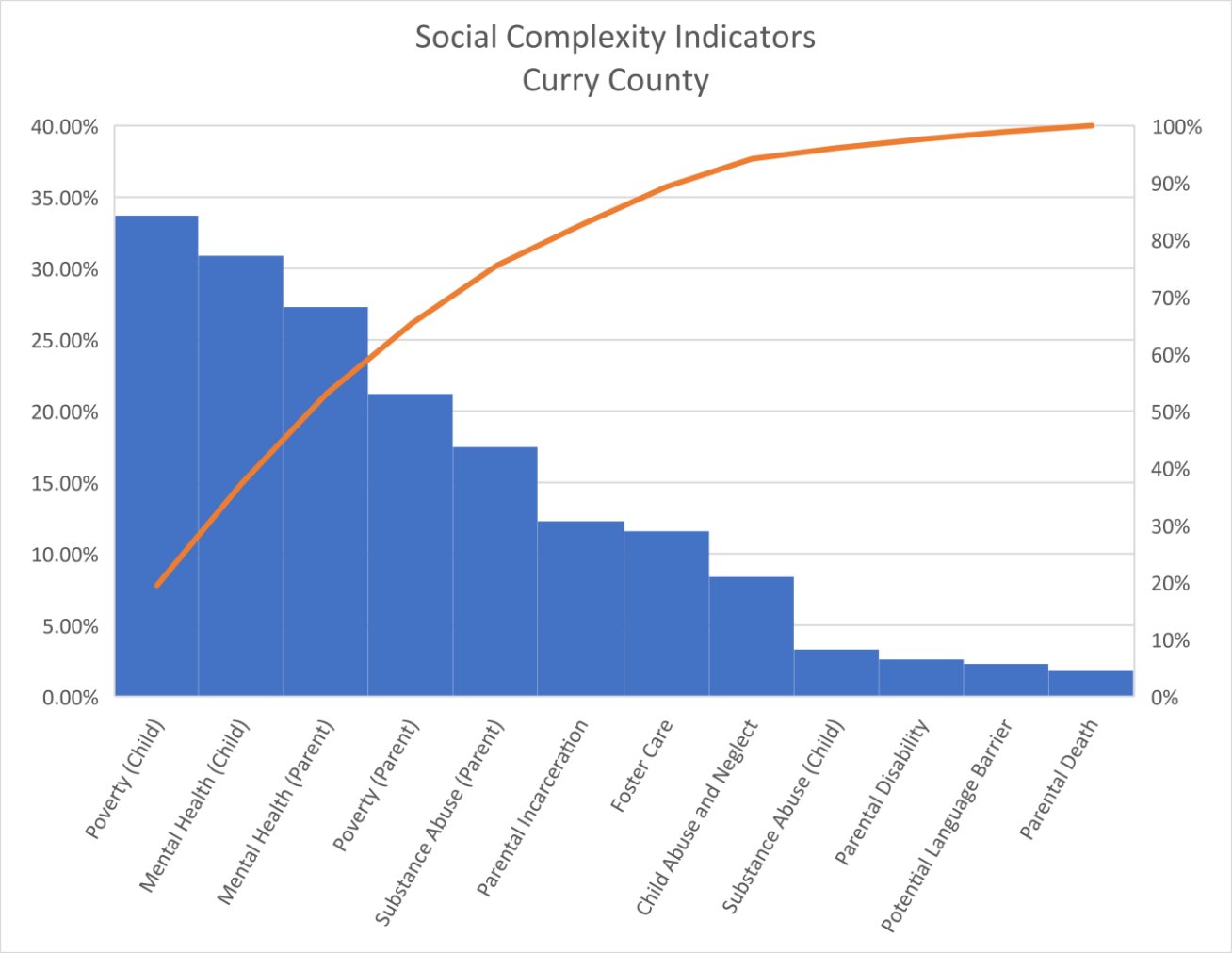

In the 2021 Child Welfare Data Book from the Oregon Department of Human Services, Coos County reported a rate of 22.4 per 1,000 children as victims of child abuse or neglect. Curry County reported a victim rate of 21.5 per 1,000 children.

The social complexity indicators summarized in the Children's Health Complexity Data closely align with many indicators of trauma from the ACEs study. Social complexity indicators reported in the Children's Health Complexity Data include poverty (child or parent), foster care, parental death, parental incarceration, mental health (child or parent), substance abuse (child or parent), child abuse and neglect, potential language barriers, and parental disability.

While Coos reported a lower rate than in 2019 and Curry's rate remained nearly unchanged from the previous year, both continue to be higher than the statewide victim rate of 15.7 per 1,000 children. As of October 2021, 44.2% of all Coos County children have 3 or more indicators of social complexity. (Source: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Coos-2021-October.pdf) This is up from the 2020 report of 43.2%. The leading cause of social complexity issues is the Mental health of the parent at 46.2%, followed by poverty at 41.9%.




Curry County has 26.8% of all children with 3 or more Indicators of social complexity. (Source: https://www.oregon.gov/oha/HPA/dsi-tc/ChildHealthComplexityData/Curry-2021-October.pdf) Poverty is the leading contributor to social complexity and the Mental Health of the Child is the number two contributor.




Note: Due to reporting rules from ICS, populations with low counts (n ≤ 10) are masked and reported as NA. For 26% of children in the statewide dataset, it was not possible to link the child to either parent.

Supporting efforts to mitigate trauma and increase resilience are priorities in both the Coos and Curry county 2019 – 2022 Community Health Improvement Plans.

The COVID-19 pandemic, resulting state of emergency declaration, and protective orders issued in 2020 have likely negatively impacted many of these indicators of social complexity and adverse childhood experiences. There is still much we do not know about the long-term effects of the pandemic, but we continue to hear from our Consumer Advisory Councils, provider network, staff, care coordinators and case managers, and community partners that findings ways to mitigate and prevent trauma and build community resilience are a priority for us all.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

South Coast Together is a community collaborative focused on fostering resilience in Coos and Curry counties. Its goals are to engage community members as agents of change in preventing the accumulation of Adverse Childhood Experiences (ACEs) and to build resilience in children, adolescents, and families. The Steering Committee is a 15-person, multi-sector group, including community members. We also have a dedicated Trainers Group, currently made of up ACEs Master Trainers (5), Presenters (9), and a few others working towards becoming an ACEs Master Trainer.

In June 2017 Advanced Health began convening community-wide planning meetings with broad cross-sector representation, including CCO delegates and providers, as well as other community partners from early childhood education, K-12 education, the local community college, juvenile department, CASA, and domestic violence prevention, among others. The goal of these early meetings was to obtain buy-in from community stakeholders and secure funding to support the initiatives. Community agencies were recruited to contribute to a funding partnership and to nominate a staff member or partner to participate in the ACE Master Trainer program. Twelve individuals were selected from throughout Coos and Curry counties and completed the ACE Master Training. These Master Trainer candidates were then available to train in pairs and raise awareness about ACE in the community. After they completed their training and presentation requirements, they will become certified ACE Master Trainers

In November 2017 a steering committee and a metrics committee were seated to provide a cross-sector community infrastructure to guide the initiative and produce a comprehensive implementation and measurement plan for Coos and Curry counties. In 2018 a communications committee was established, and the program adopted the name South Coast Together and a logo to use on public materials and communications.

Throughout 2018, the project focused on raising community awareness and promoting education around ACEs and Trauma-Informed care. Two of the Master Trainer candidates completed the required amount of training hours and gained their ACE Master Trainer certification. Over 1,200 individuals in Coos, Curry, and Douglas County received training with reports of high impact on the training evaluations. Key informant interviews were conducted with thirty participants and focused on four topics: community overview, community partnerships and leadership, how people and organizations make decisions, and how the community learns and improves. The steering committee also provided input on perceptions of population challenges at various stages in life and served as a focus group to inform understanding of prevailing beliefs about the dynamics that contribute to those challenges. The information from the key informant interviews and input from the steering committee was synthesized by the consultants from ACE Interface into an assessment report including recommendations for continued action.

South Coast Together work continued in 2019, with efforts focusing on expanding leadership. Leadership expansion is one of the core principals of building a Self-Healing Community. To accomplish this, we trained additional “Presenters”, supported training for Family Café facilitators and the Family Café events, and completed strategic planning for the initiative by a Core Group of multi-sector participants.

In 2019, we increased our number of Certified Master Trainers to five. We also held a two-day presenter training for four local presenters. Presenters are prepared to teach the basic ACEs training curriculum. By increasing our number of Presenters and Master Trainers, we can serve more people in our community and meet the demand for training without burdening our trainers, who mostly hold other jobs as well.

Another endeavor completed in 2019 was hosting a Family Café training. Ace Interface, our consulting group, recommended Family Café training to increase community capacity and distribute leadership in our community. We partnered with our local Pathways to Positive Parenting chapter to procure grant funds from the Oregon Parenting Education Collaborative to hire a consultant to provide the 6-hour training to 41 community members and professionals, with the request that those attending the training hold individual Family Café in the community, and to fund those café events. A Family Café is an organized event with a host, designed to facilitate communication and create space for dialogue around important issues to those in attendance. Family Café facilitators hosted at least 15 cafés in 2019, with topics ranging from “Grandparents Raising Grandkids” to “Parenting Challenges” and “Transportation Barriers “. Because of the “train the trainer” model for Family Cafés, there were Family Cafés planned into 2020 as well.

Also in 2019, we convened a Core Group of participants for strategic planning of the initiative including fiscal sustainability. The group determined that to reach some of our longer-term goals, we would need to begin applying for

grants and other funding sources. This required a transition of our backbone agency to an organization that had recognized non-profit status. We also wanted to find an organization invested in work in both Coos and Curry counties, and whose mission, vision, goals, and other work aligned with that of South Coast Together. A multi-month process occurred, which eventually led to the transition of the South Coast Together initiative and its current funding to our regional South Coast Education Services District (ESD). In January 2020, South Coast Together completed the transition to the South Coast Education Services District as the new backbone agency.

2020 marked the fourth year of the collaborative, and although some plans and goals changed due to the Covid-19 Pandemic, South Coast Together still found relevancy and opportunities to promote its objectives. Training community members and professionals on the science of Adverse Childhood Experiences (ACES) science, through curriculum from ACE Interface, has been at the foundation of the group's work. We decided to use some of our funding to purchase an additional three years on the license for our ACE interface curriculum. From this curriculum, we delivered 19 trainings in 2020. Trainings at the beginning of the year were in person, and later we switched to a zoom/virtual training platform. Three of the trainings were for medical facilities, 11 were for school districts and the regional education services district, five were for community organizations. We have trained over 1,400 individuals in total in our communities.

Another goal we had for 2020 was to host a community event around ACES awareness. It quickly became evident that an in-person event would not be possible this year. Our Steering Committee decided to host several virtual "Community Zoom Sessions". We used some funding to pay for national expert and consultant, Laura Porter, to facilitate the sessions. The first one occurred in May 2020 and the focus was "Covid Conversation", we had approximately 30 attendees. Our agenda included time for participants to reflect on the impact of Covid on themselves personally and in the community, followed by education from Laura Porter around community capacity development, and then short comments from four community leaders around the question: "What are two or three themes you are seeing in your role that other may benefit from knowing?". We discussed emerging resources and partnerships as a large group and then finished with a reflection on what participants are taking away from this event.

We held another event in August 2020, the theme was around Supporting Families. Many of the participants work in schools or directly with children, so we wanted to help prepare them for returning to school in the fall. Again, we provided time for reflection at the beginning of the event, "identify one word or feeling that comes to mind when you think about responding to children given the significant and various stressors that families are under". Laura Porter next provided information about the impact of stress from the science and early learning specific to Covid from other communities and countries. Time was provided for five speakers from various organizations to talk about strategies, partnerships, and resources available or emerging to support families. The participants were then moved into virtual break-out groups for small discussions, and then a final report out to the whole group at the end. There were about 40 participants for this event.

Our last event of 2020 was held in October and took a deeper dive into lesser-known resources in the community available to support children and families, as well as a discussion on reducing silos. Then we spent time discussing how to generate empathy when we are all experiencing stress. We did some moderating and facilitating as a group, and then had smaller breakout groups again. The themes were picked by getting feedback from participants in the previous sessions. We had again about 30 participants.

The last project we spent time on in 2020 was the creation of a Parenting Guide based on brain science. We are calling it the "Help that Helps" guide. A small group of South Coast Together participants, along with consultants from Lieberman Group and Ace Interface, have been working on the guidebook for several months. It is nearly complete and will also feature artwork by a youth. Grant money from the United Way and the Advanced Health Community Health Improvement Plan was used to fund consultation and printing costs.

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

In 2021 The "Help that Helps" guide was finished, printed, and was out for distribution at school districts and parent meetings. The Spanish translation is in development and is expected to be finished in Q2 2022. Parent Cafés for the "Help that Helps" guide will begin Q1 2022. The first audience will be the Regional Parent Advisory Council representing all 10 school districts in our service area all 10 districts are expected by Q4 2022. Follow-up will be at 3 Professional Development days throughout the year.

Six Parent Cafés in partnership with the South Coast Extended School District (SCESD), were held in 2021 including Coquille and Brookings School Districts. Four (4) bilingual Cafés were held in 2021 where parents learned about mental health, managing stress, COVID vaccines, and local resources including Coos Health and Wellness (CHW). Our partners there also included Dr. Mike and Friends Pediatrics, CHW, OHSU, and Coos Hispanic Allies.

By the end of 2021, South Coast ESD had all staff initially trained in ACEs and self-regulation and resilience training. One parent Café on the Help that Helps guide will be held in each School district by year-end 2022.

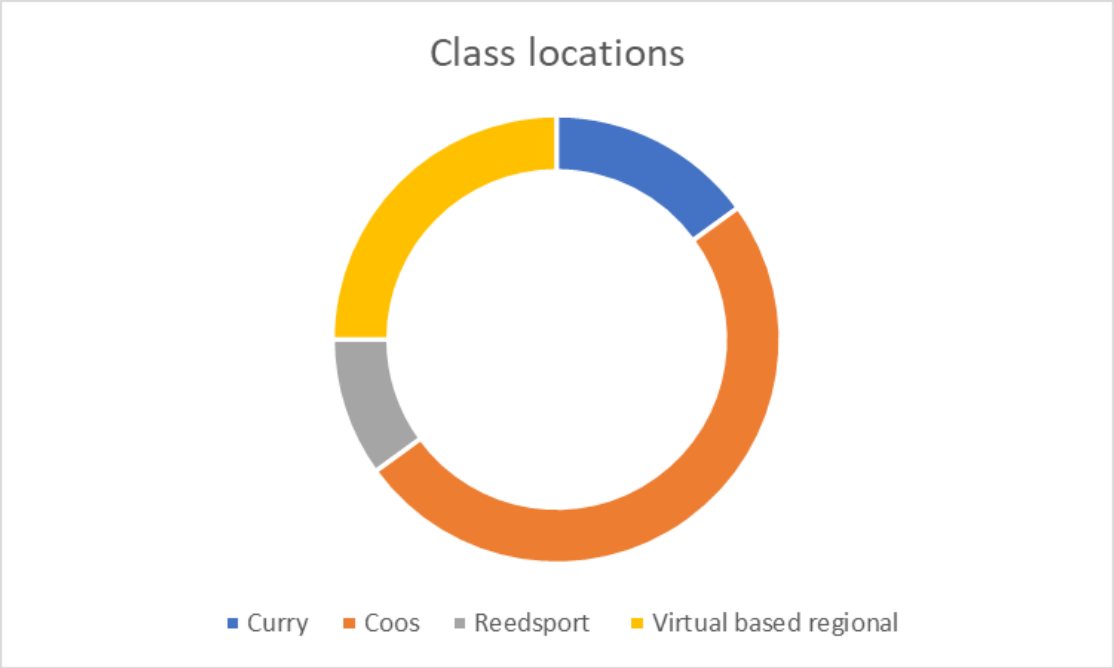
Advance Health's role on the steering committee was to help advise and support the South Coast Together focus training in the needed areas. In 2021, through the support of Advanced Health, South Coast Together was able to continue in its mission to build understanding and compassion for others - essential tasks made more difficult by the continuation of the pandemic. Specifically, financial and in-kind support from Advanced Health and other community partners enabled South Coast Together to:

- Provide in-person and online ACES and NEAR Science training for trainers and presenters resulting in (21) pieces of training for a total of (44) hours of presentations for CASA, Every Child Coos, the Port Orford School District staff, the regional Student Support Specialists (SSS) in each school, all (SCESD) staff, Coos Health and Wellness (CHW) staff and the staff of Advanced Health. In addition, Self-Regulation and Resiliency training was provided to the regional SSS and the CASA volunteers.
- Support a (6) hour a week administrator who served as lead trainer, grant writer, and as the backbone for the Leadership team in developing the mission and vision of SCT, monitoring the program budget, and creating agendas for our monthly Steering Committee meetings.
- Support a (5) hour a week secretary to manage online and email communications, facilitate zoom meetings, create presentations as assigned, translate documents, and coordinate the webpage design and SCT marketing.
- Finalize the Help that Helps guidebook in both Spanish and English and begin distributing the guide nationally.
- Create a curriculum to accompany the Help That Helps guidebook for those who attend Parent Cafes or other events and receives the HTH Guide.
- Conduct a spring Presenter Training for Coos, Curry, Jackson, and Douglas County.
- Begin collaboration across the South Coast with Creating Community Resilience and Southern Oregon Success to further the mission of both groups.
- Developed a Strategic Plan with goals for 2021-2023:
    - **Expanding Education/Awareness:**
        - Support trauma-informed school initiatives with ACES/NEAR to all School Districts in the region during the 2021-2022 academic year.
        - SCESD-SCT, (10) trainings estimated between July 2021 and the end of June 2022
        - Increase education, awareness, and engagement in the work of SCT over our baseline year of 2020-2021 by June 30th, 2022 by 10% with **the goal for (40) trainings this year**.
    - **Family Connections:**
        - Provide additional sessions (Cafes, ACES/NEAR, Self-Regulation, and Resilience, Help that Helps Guide) with school districts and other partners for supporting the implementation of trauma-informed strategies. Parents/school boards, etc.
        - Develop a strategy to create and pilot a series of Family Café's to encourage the growth and learning of family systems and develop relationships with one another with the Help that Helps

Guide as the framework.

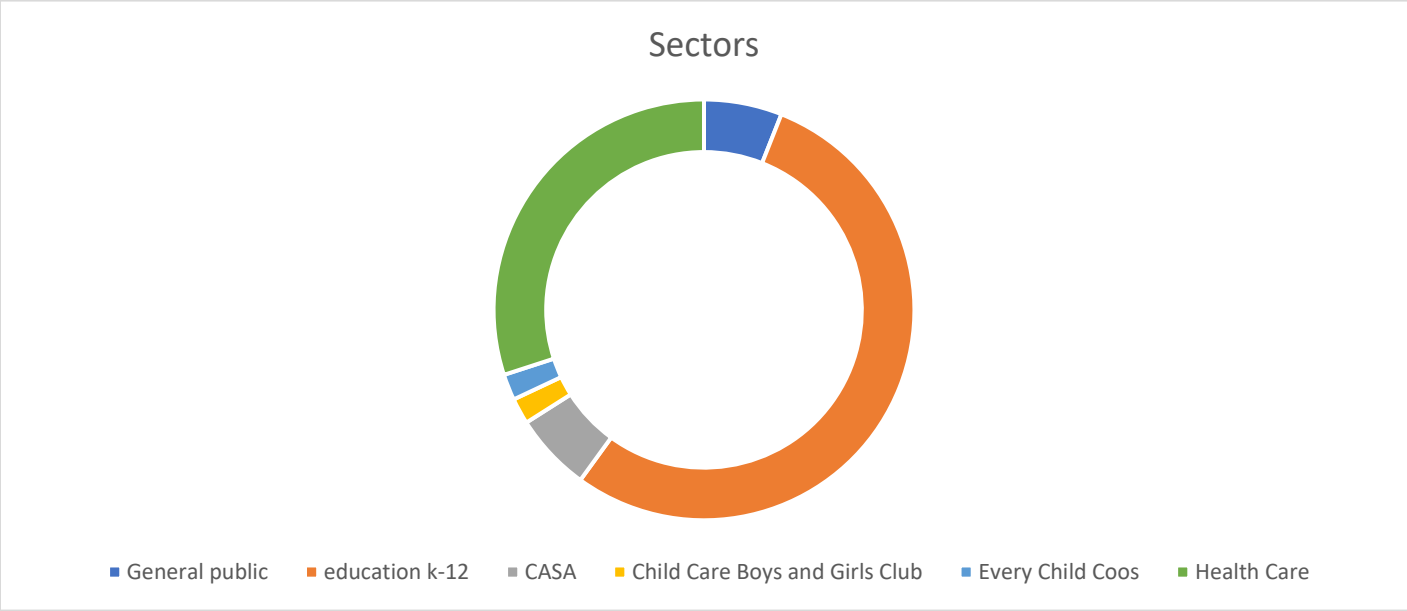
- **Community Connections:**
  - Make the Help that Help Guidebook broadly available for purchase and/or free copies as funding allows to Coos and Curry communities, including AllCare, Advanced Health, health care provider offices, schools for parent cafes, CH&W, WIC, Mental Health, and other community groups.

In 2021 there were 40 ACEs presentations in the region, 6 in Curry County, 20 in Coos County, 4 in Reedsport, and 10 were region-wide virtual presentations.

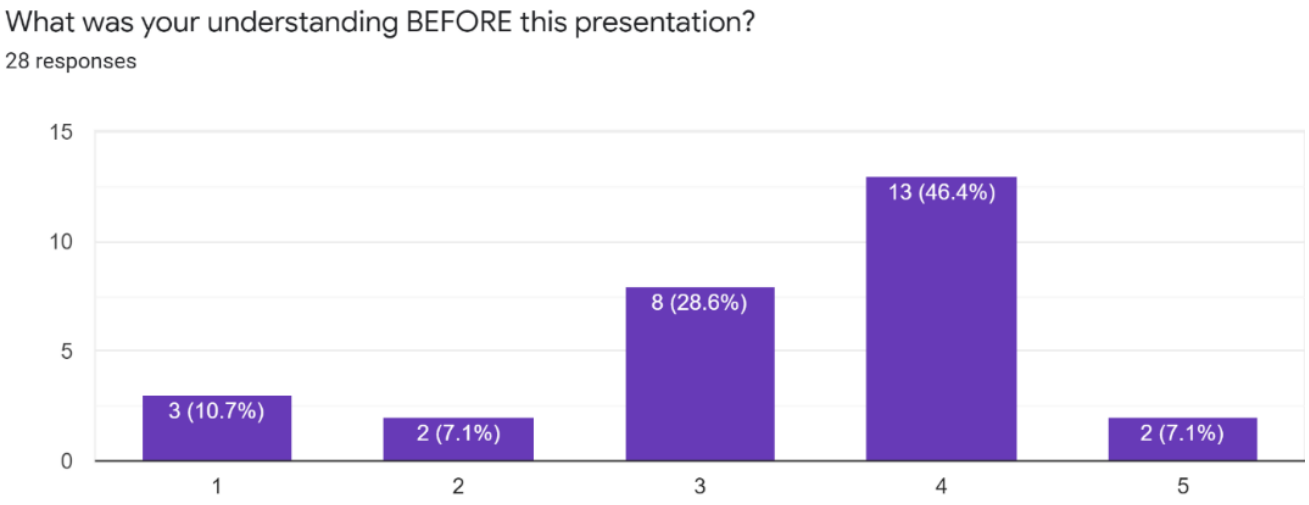


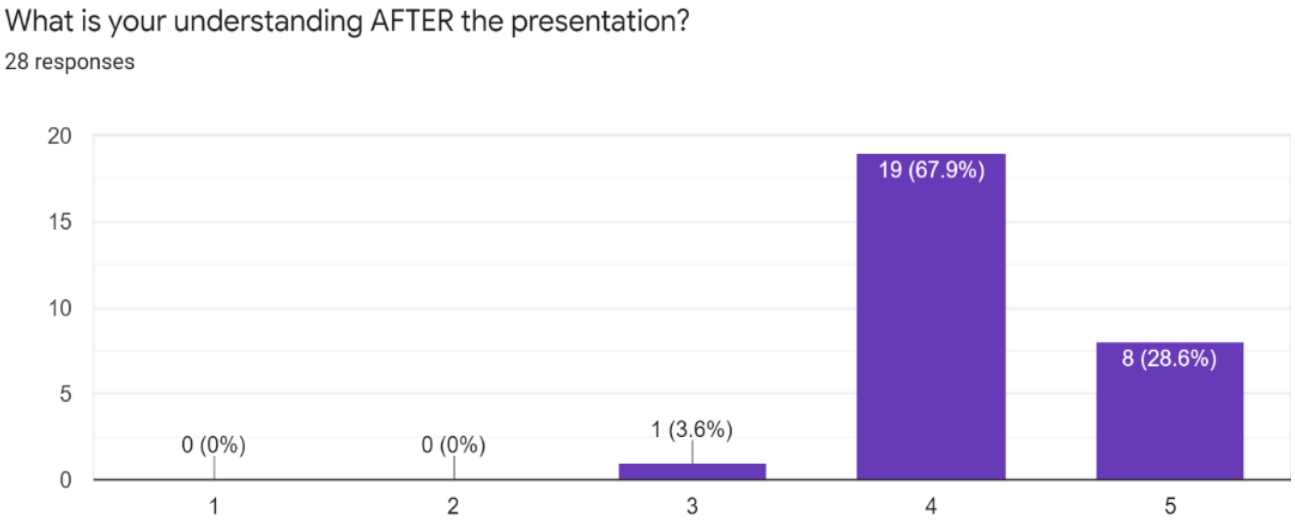

The breakdown of the presentation audiences is as follows.

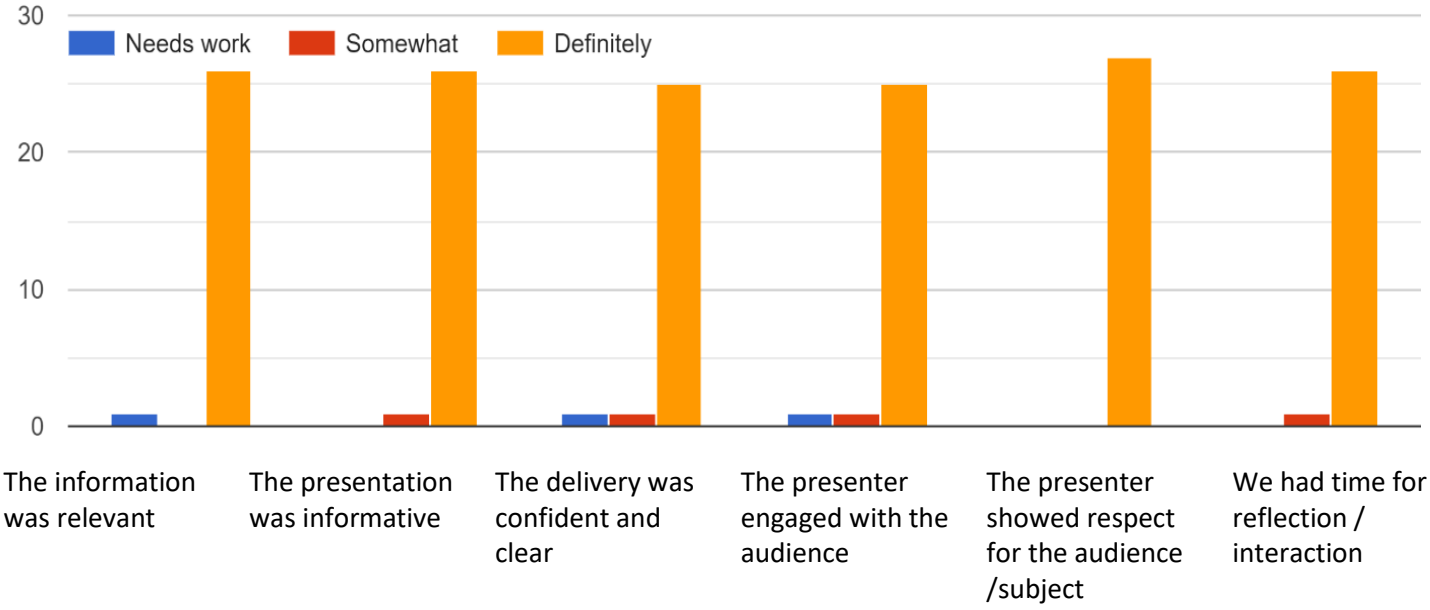
- 3 to the general public
- 27 to education (k-12)
- 3 CASA – Court Appointed Special Advocates
- 1 Childcare (Boys and Girls Club)
- 1 Every Child Coos (organization dedicated to supporting and recruiting foster families)
- 15 healthcare




Below you will see how participants evaluated their own ACEs knowledge BEFORE and AFTER the presentations. Survey question asked participants to rate their prior and post knowledge on a scale of 1 (no knowledge) to 5 (extremely knowledgeable).






## E. **Brief narrative description**:

South Coast Together chose The Self-Healing Communities Initiative as the framework for the communities of Coos and Curry Counties to work toward building resiliency to mitigate the effects of ACEs for those who have already experienced trauma and to prevent traumas for future generations. Its goals are to engage community members as agents of change in preventing the accumulation of ACEs and to build resilience in children, adolescents, and families. Efforts to promote community awareness of ACEs, neuroscience, and resiliency practices across a broad swath of sectors, including the public, will continue, with presenters adjusting and adding to trainings in response to feedback from the community members, organizations, and service systems receiving training.

## OHA Transformation and Quality Strategy (TQS) CCO: Advanced Health

Advanced Health will continue to provide financial support for South Coast Together and an Advanced Health staff member will participate on the South Coast Together steering committee. In addition, a consumer CAC member is also a current member of the steering committee. Several staff members are certified trainers or presenters and will continue to provide trainings and presentations as requested. The ACE training provided by South Coast Together is also an integral part of Advanced Health's staff training and provider network training plans.

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

**Activity 1 description**: Continue to provide ACE trainings and follow-up trainings at no cost to the community, across all sectors, including health care, education, law enforcement, social services, parent groups, spiritual communities, and local tribes.

☐ Short term or ☒ Long term

| **Monitoring measure 1.1** | Number of training sessions completed | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 40 sessions in 2021<br>20 sessions in 2020<br>40 sessions in 2019 | 40 sessions in 2022 | 12/2022 | 40 sessions in 2023 | 12/2023 |
| **Monitoring measure 1.2** | Add new Presenters to the training team to support the training schedule and reach new audiences. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 8 as of 12/2021<br>4 as of 3/2020<br>0 as of 1/2019 | 5 presenters trained | 12/2022 | 5 presenters trained | 12/2023 |

**Activity 2 description**: Support trauma-informed school initiatives by presenting to all school districts in the region and providing follow-up sessions to support the implementation of trauma-informed strategies during the 2021-2022 academic year.

☒ Short term or ☐ Long term

| **Monitoring measure 2.1** | Percentage of school districts in the region receiving education and follow-up sessions during the 2021-2022 academic year | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 0% of districts | 100% | 12/2021 | 100% | 06/2022 |

**Activity 3 description**: Create and publish a "Help That Helps" parenting guide based on brain science to be used for parent trainings, presentations, and other workshops.

☐ Short term or ☒ Long term

| **Monitoring measure 3.1** | Complete the Spanish translation of the Help that Helps guide | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| In development | Completed | 06/2022 | Begin distribution | 06/2022 |
| **Monitoring measure 3.2** | Distribution of guide through parent cafés and/or presentations | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 0 parent cafes | 10 cafés and trainings | 12/2022 | 10 Trainings | 12/2023 |

## A. **Project short title**: Member Grievance System Improvements

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

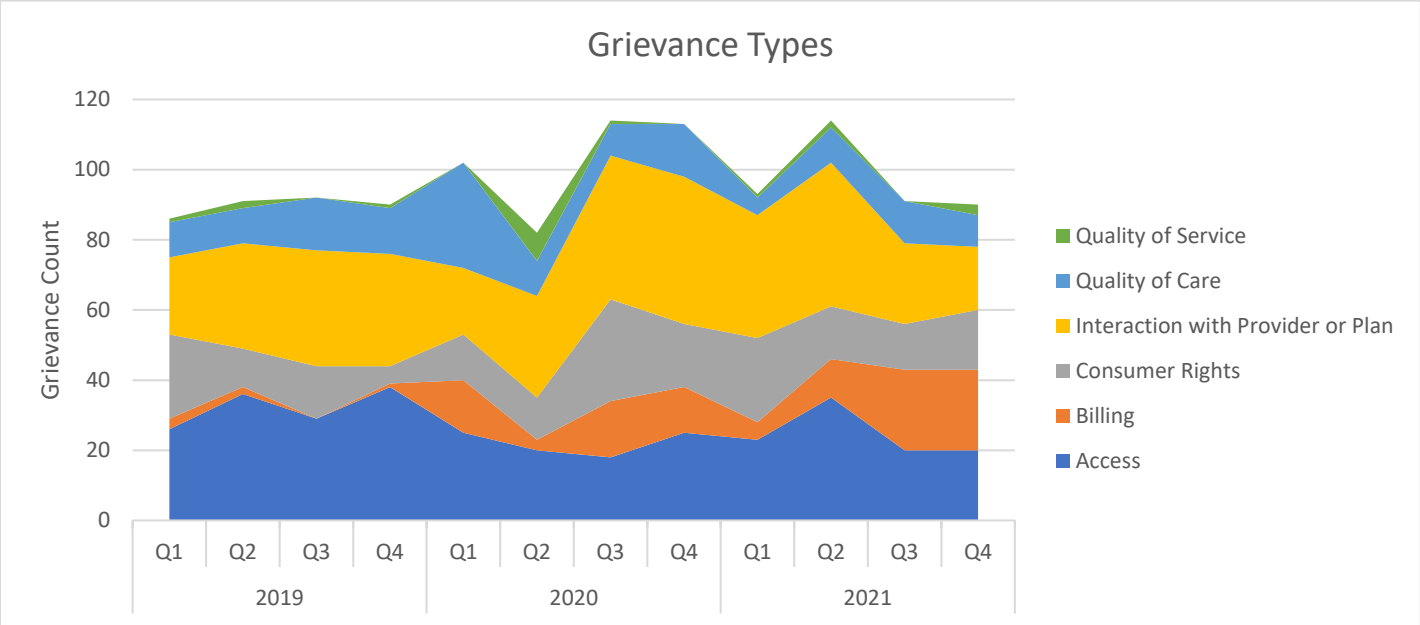
If continued, insert unique project ID from OHA: 42

## B. **Components addressed**

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

## C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health monitors data from the Member Grievance System closely for trends that can be addresses through systemic quality improvement efforts. The sharp decrease in total complaint volume in Q2 2020 is likely the result of the stay home orders issued in response to the COVID-19 public health emergency. Some services were closed or restricted for a time and people did not expect to receive those services. Complaint volumes increased in Q3 and Q4 of 2020 as stay home orders were eased and in-person services reopened with modifications and additional safety precautions in place.

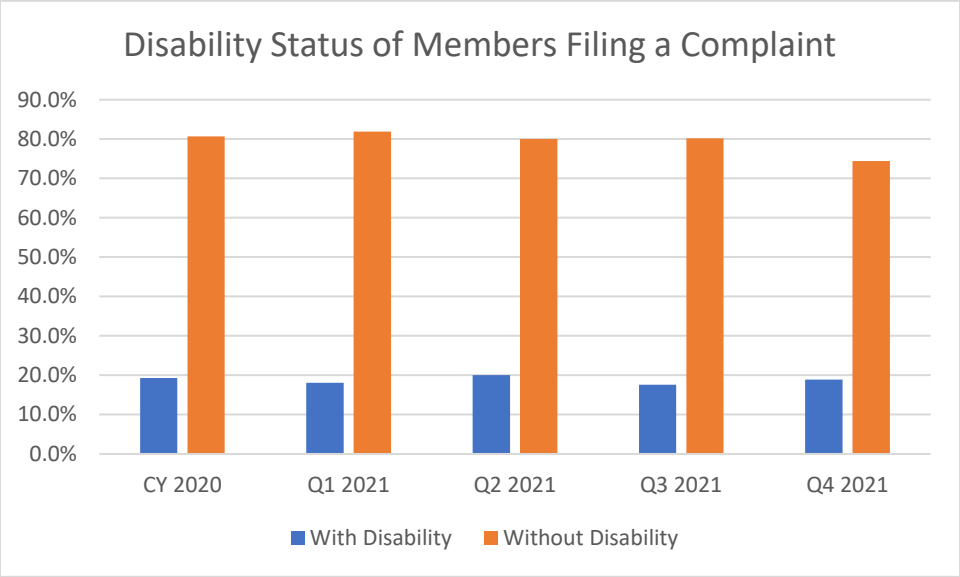



Total complaint volumes remained stable in 2021, despite increasing enrollment due to the suspension of the redetermination process while the public health emergency remains in effect. This means the rate of grievances per 1000 members declined in 2021, dropping back down below 2019 complaint rates following the increase in access and interaction with provider or plan complaints in Q2 2021.


Advanced Health tracks grievances related to cultural sensitivity by both the provider and the plan. We have had no grievances related to cultural sensitivity in the past eight quarters. We will continue to work to maintain low complaints in this category. These complaints are categorized as IP.h: Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available. In Q4 2021 and the previous eight quarters there were zero complaints in this category.

## OHA Transformation and Quality Strategy (TQS) **CCO:** Advanced Health

Advanced Health currently serves nearly 26,000 Oregon Health Plan Members in Coos and Curry Counties on the Southern Oregon Coast. 52% of Advanced Health Members are female and 48% are male. Nearly 7%, approximately 1,600 members, have one or more disabilities.




Advanced Health's primary and most complete source of data related to linguistic and cultural needs of members is the OHA 834 enrollment data. Advanced Health finds the REALD demographic data from OHA to be the most comprehensive data set available at this time. Using this REALD data, Analytics Department staff have developed a REALD demographic dashboard in Tableau to summarize the race, ethnicity, language, disabilities, and interpreter needs of Advanced Health members. The dashboard also includes a query feature to allow staff to find REALD data for a specific member. This function is used by the Grievance System Coordinator when reviewing grievance and appeal data to ensure we are offering materials in the member's language and to monitor for any trends related to equitable access to health care or the grievance system.

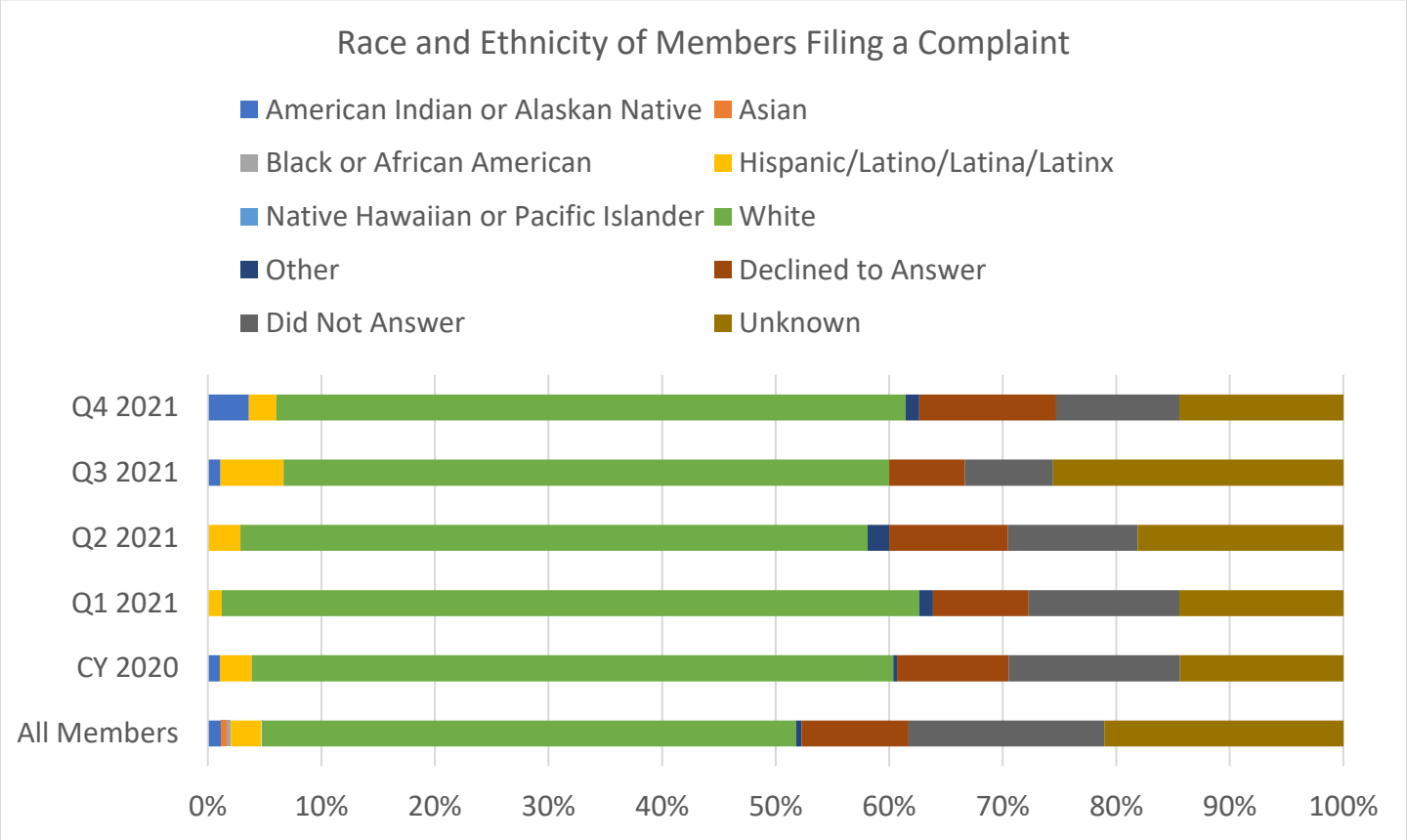
These Tableau dashboards are updated daily as enrollment and encounter data is updated.

2021 demographic data identifies the following enrollee characteristics:

| **Race and Ethnicity** | |
|---|---|
| American Indian or Alaska Native | 1.3% |
| Asian | 0.5% |
| Black or African American | 0.3% |
| Hispanic/Latino/Latina/Latinx | 2.9% |
| Native Hawaiian or Pacific Islander | 0.1% |
| White | 46.8% |
| Other | 0.5% |
| Declined to Answer | 9.3% |
| Did Not Answer/Unknown | 38.1% |

Race and ethnicity data from the 834 enrollment files is matched by member ID to data from the grievance tracking system, allowing for an analysis to better understand whether our grievance system is being accesses equitably by members of all races and ethnicities. In the chart below, we compare the data for all members to calendar year 2020,

and to 2021 by quarter. We aggregate the data quarterly so we have a large enough sample of information to give some confidence in the proportions and to be able to watch for trends throughout the year. In 2021, this data analysis became part of the grievance data reviewed by the Interagency Quality Committee. There were no notable trends observed in 2021.




**Language**

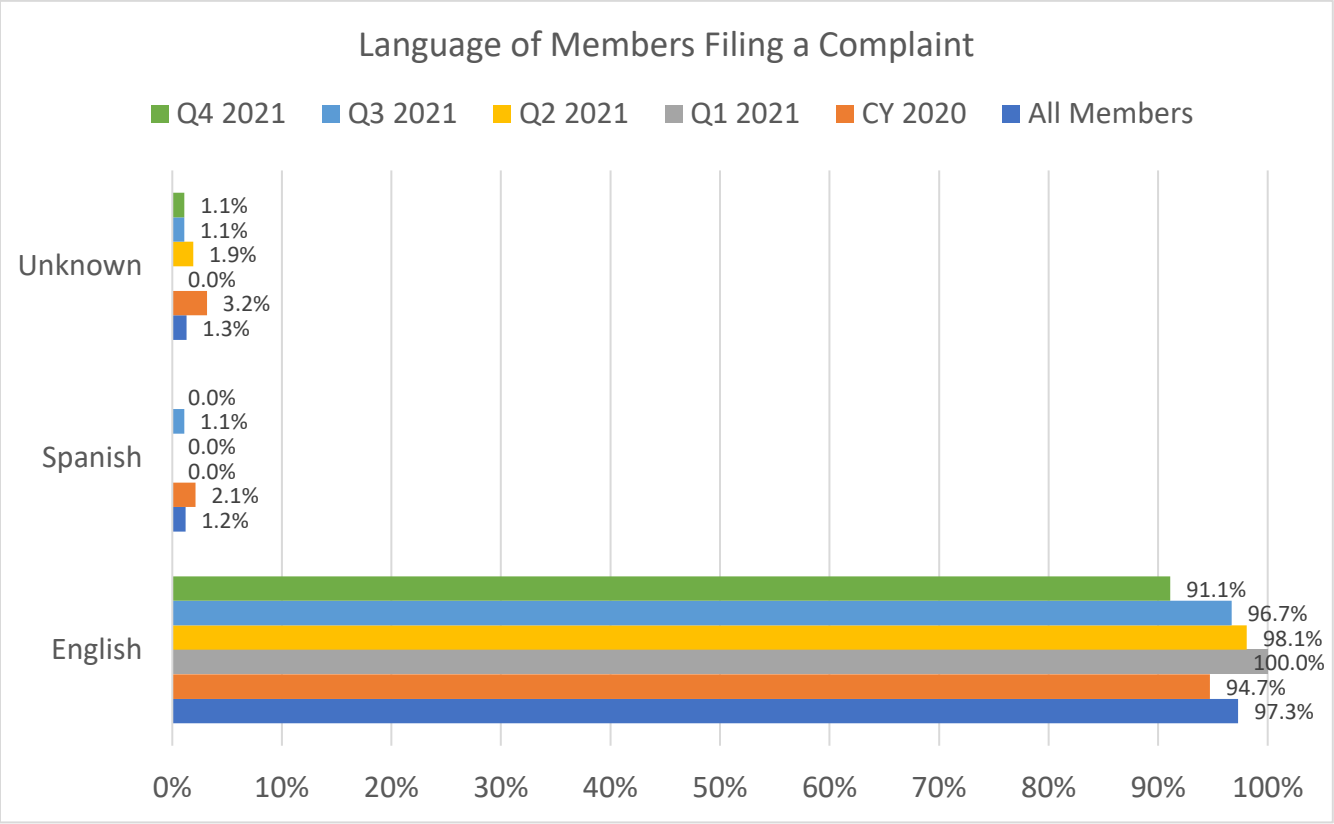
| | |
|---|---|
| Unknown | 1.3% |
| Chinese | 0.1% |
| English | 97.3% |
| Spanish | 1.2% |

*Note languages reported by fewer than 20 members are suppressed from this report

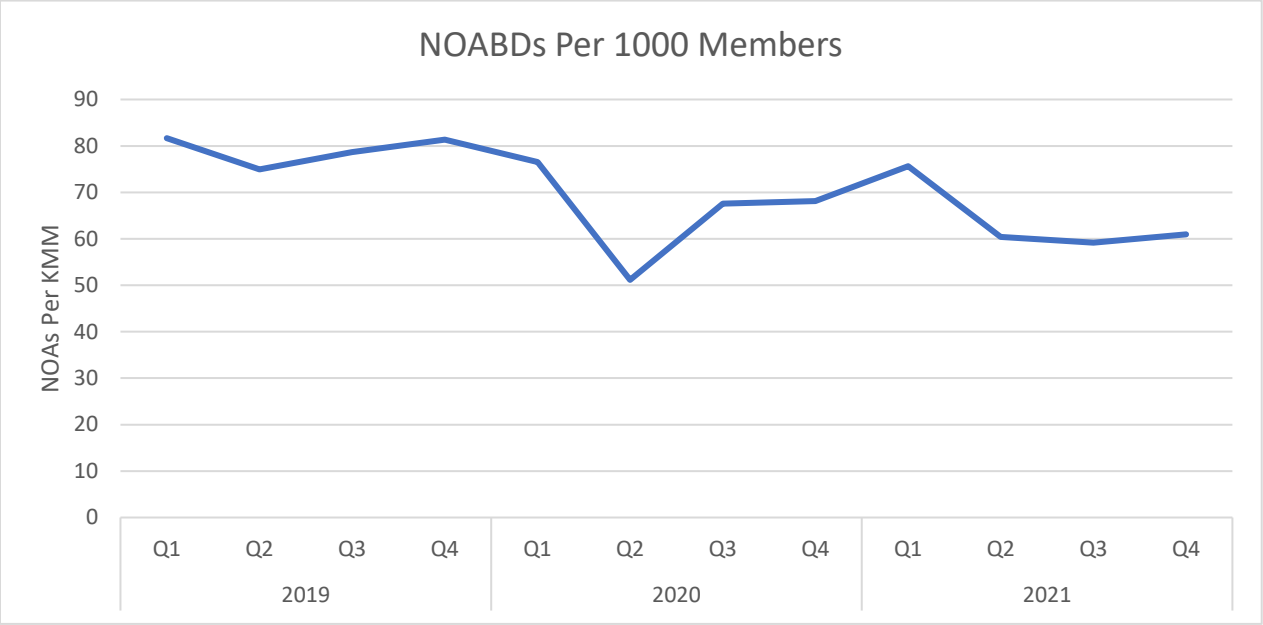
Spanish is the most common non-English language spoken by Advanced Health Members, with 1.2%, or about 300 Members, indicating that their primary language is Spanish.

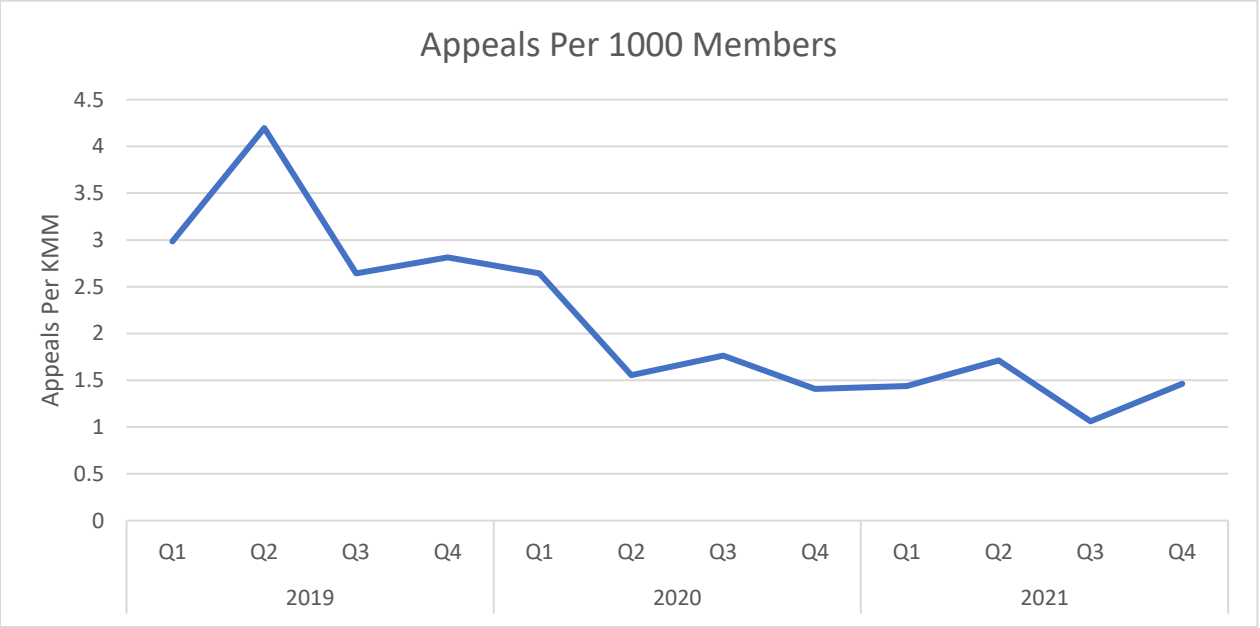
In a similar fashion as described above, the spoken language of members who filed complaints was also analyzed in 2021 and reviewed by the Interagency Quality Committee. Improving language access and interpreter services has been an initiative at Advanced Health for several years and it is important to use the data we have available to monitor for equitable access to health care services, but also for access to systems that support member rights, such as the grievance system. In 2021 we see only a small number of complaints from Spanish-speaking members. It is possible that we are missing an opportunity to hear from these members, or it is possible that due to small sample sizes (approximately 30 to 35 complaints per month) and the relatively small population that we can expect to see some months with 0 complaints for Spanish-speaking members. However, this is an area that will require more investigation in

2022 to ensure we identify any unknown barriers. As part of our project to improve access to language interpretation services (detailed in another section of this TQS report), we are planning to hold listening sessions with the Coos Hispanic Allies and other groups to better understand their barriers to access.

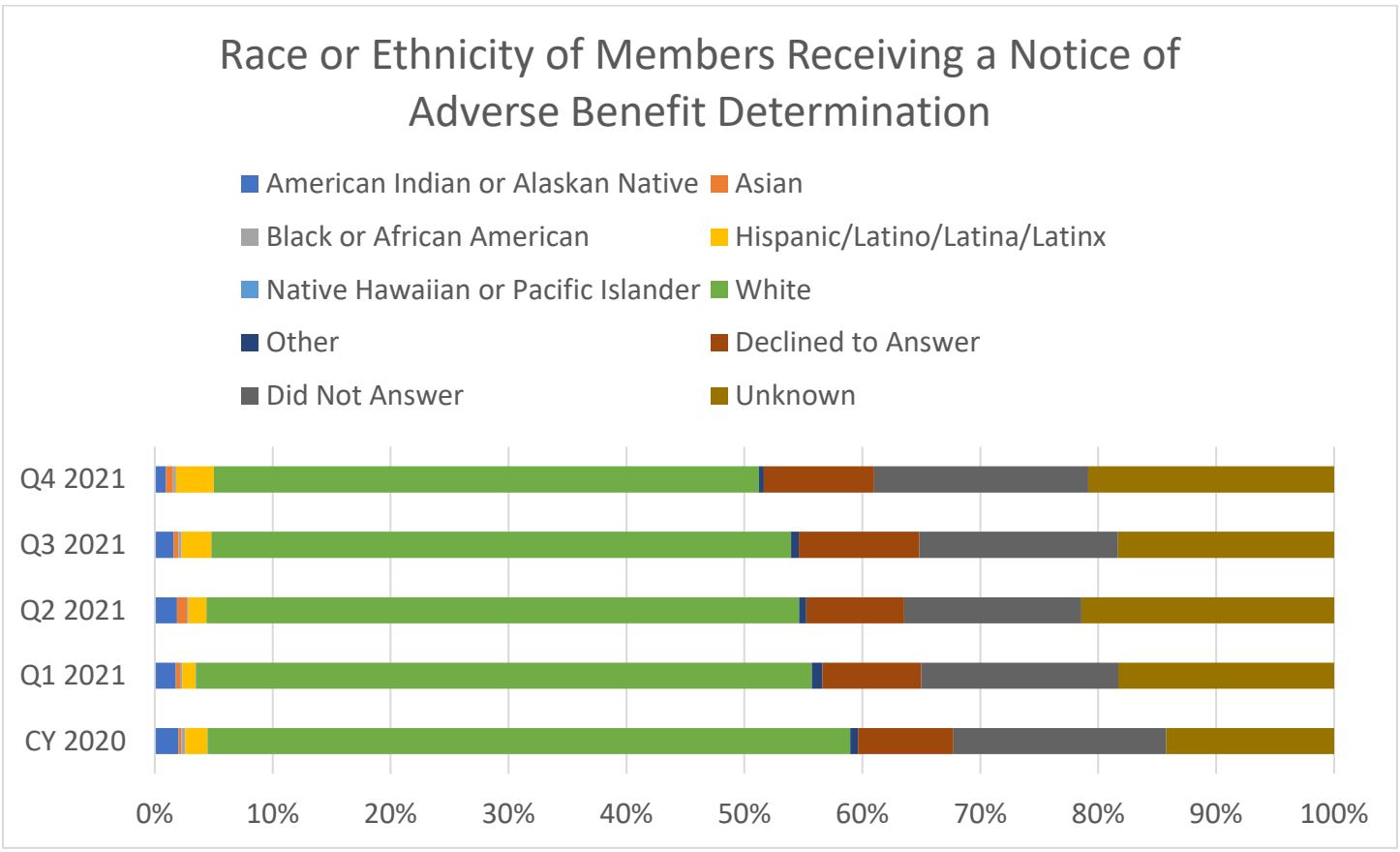


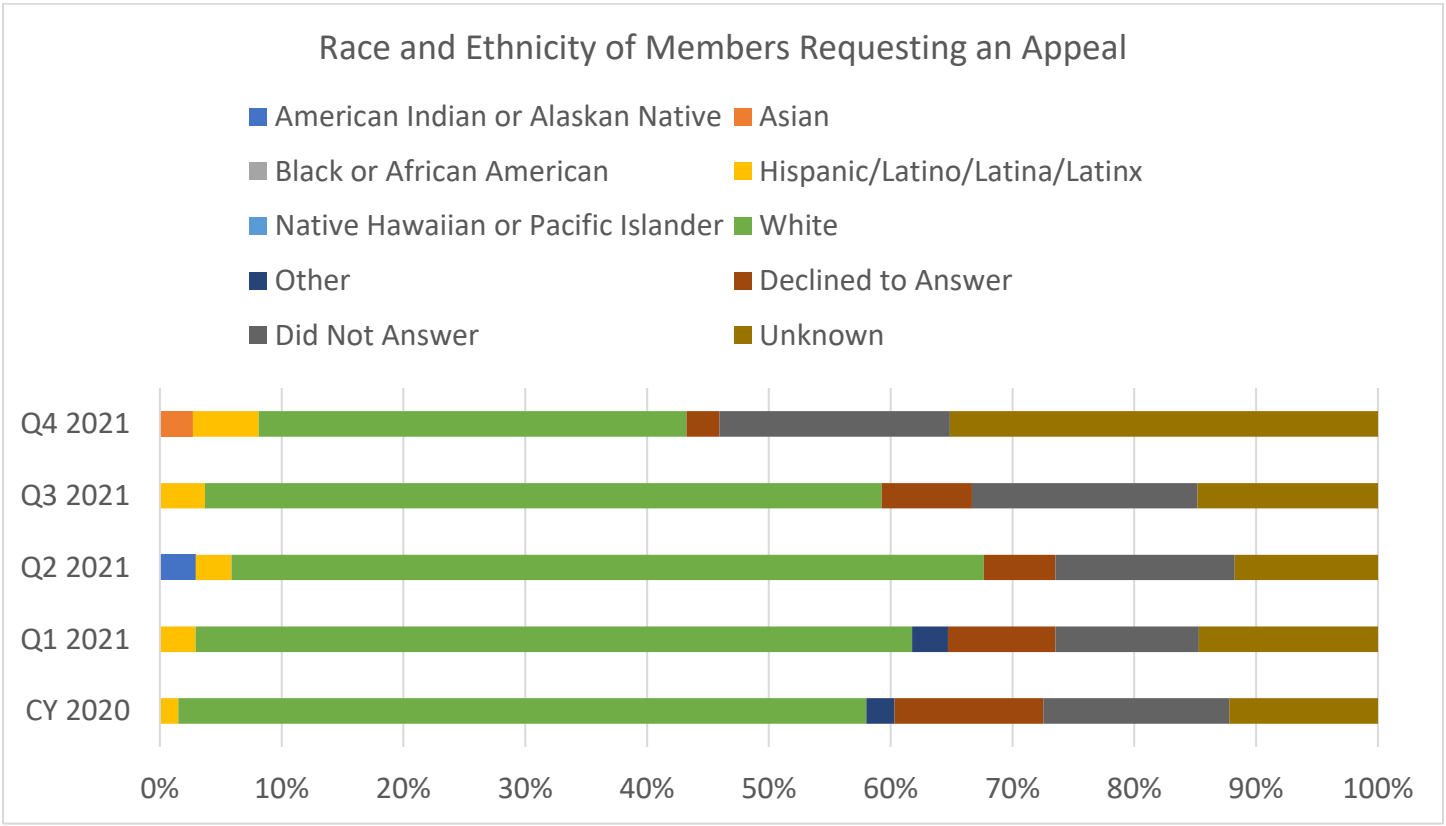

The rate of Notices of Adverse Benefit Determination (NOABDs) per 1000 Members and Appeals per 1000 Members both declined in 2020. The abrupt decrease in volume in Q2 2020 was due to the shutdown of facilities, cancellation or postponement of elective procedures, and the stay home orders in response to the COVID-19 pandemic. Providers were not able to see as many patients or provide as many services as usual in Q2 2020, and so the overall volume of services requested, and services performed was lower. Many of the initial restrictions in response to the pandemic have been lifted or modified, the overall volume of prior authorization requests has returned to pre-pandemic levels. The rate of NOABDs per 1000 members declined in Q2 2021 and remained stable through Q4 2021. The rate of appeals per 1000 members increased in Q2 2021, decreased in Q3 2021, and returned to nearly the same levels as Q4 2020 and Q1 2021. This is likely the result of natural variation.

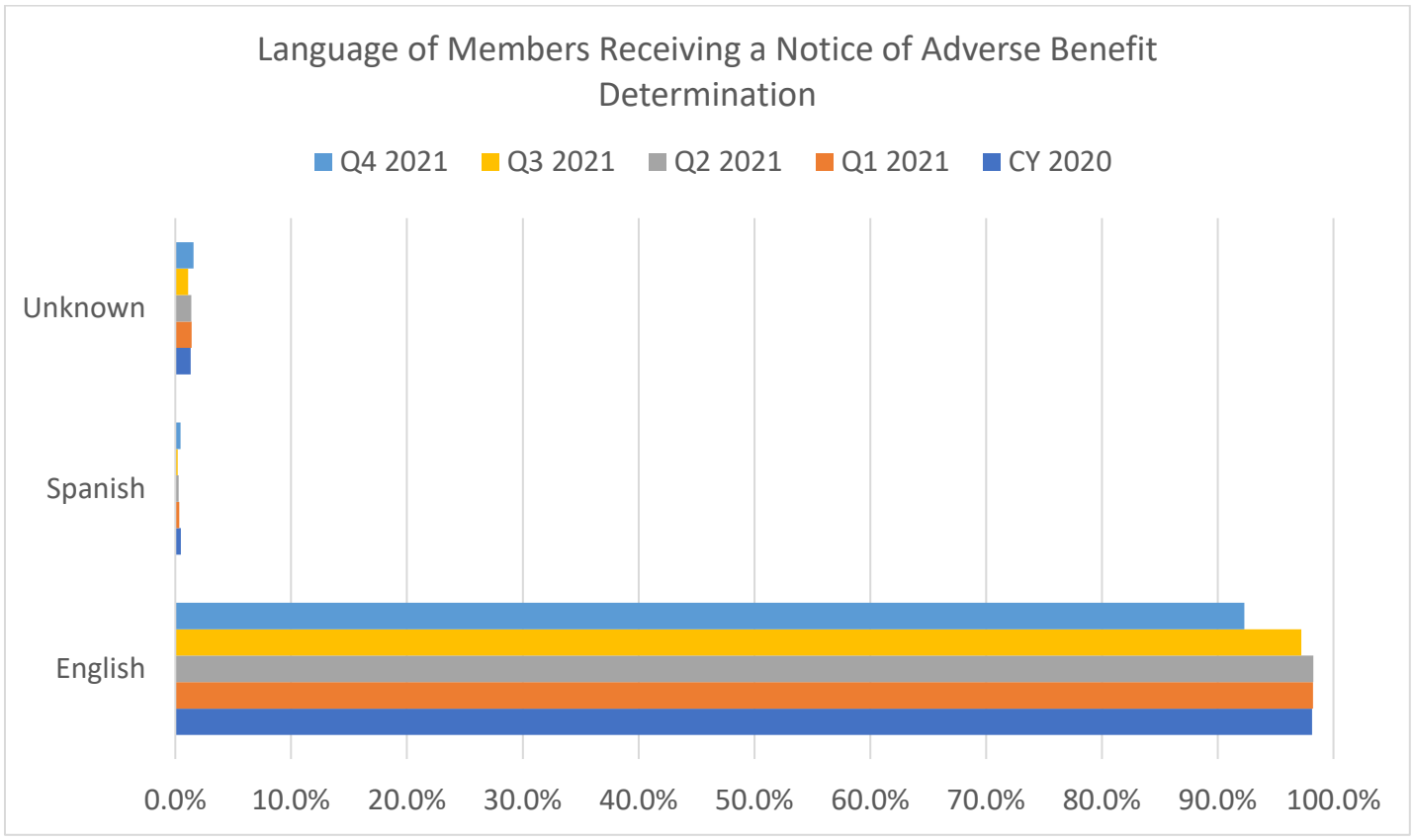


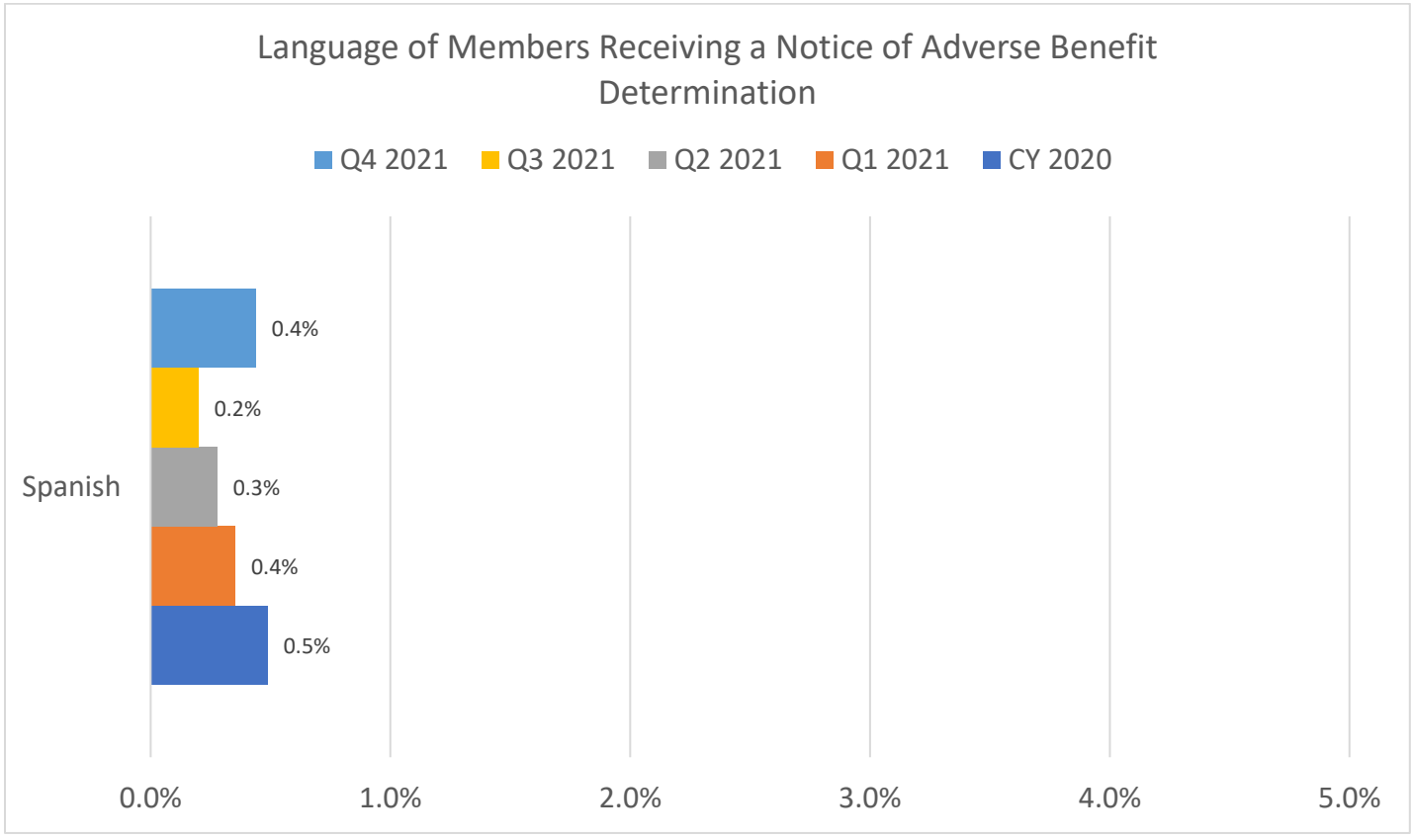




Below is an analysis of member race and ethnicity for NOABDs and for Appeals. Similar to the analysis discussed above for grievance data, this information is monitored and reviewed by the Interagency Quality Committee.


Race or Ethnicity of Members Receiving a Notice of Adverse Benefit Determination
American Indian or Alaskan Native
Asian
Black or African American
Hispanic/Latino/Latina/Latinx
Native Hawaiian or Pacific Islander
White
Other
Declined to Answer
Did Not Answer
Unknown
Q4 2021
Q3 2021
Q2 2021
Q1 2021
CY 2020
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Race and Ethnicity of Members Requesting an Appeal
American Indian or Alaskan Native
Asian
Black or African American
Hispanic/Latino/Latina/Latinx
Native Hawaiian or Pacific Islander
White
Other
Declined to Answer
Did Not Answer
Unknown
Q4 2021
Q3 2021
Q2 2021
Q1 2021
CY 2020
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Language of Members Receiving a Notice of Adverse Benefit Determination
Q4 2021
Q3 2021
Q2 2021
Q1 2021
CY 2020
Unknown
Spanish
English
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
100.0%


Language of Members Receiving a Notice of Adverse Benefit Determination
Q4 2021
Q3 2021
Q2 2021
Q1 2021
CY 2020
Spanish
0.4%
0.2%
0.3%
0.4%
0.5%
0.0%
1.0%
2.0%
3.0%
4.0%
5.0%

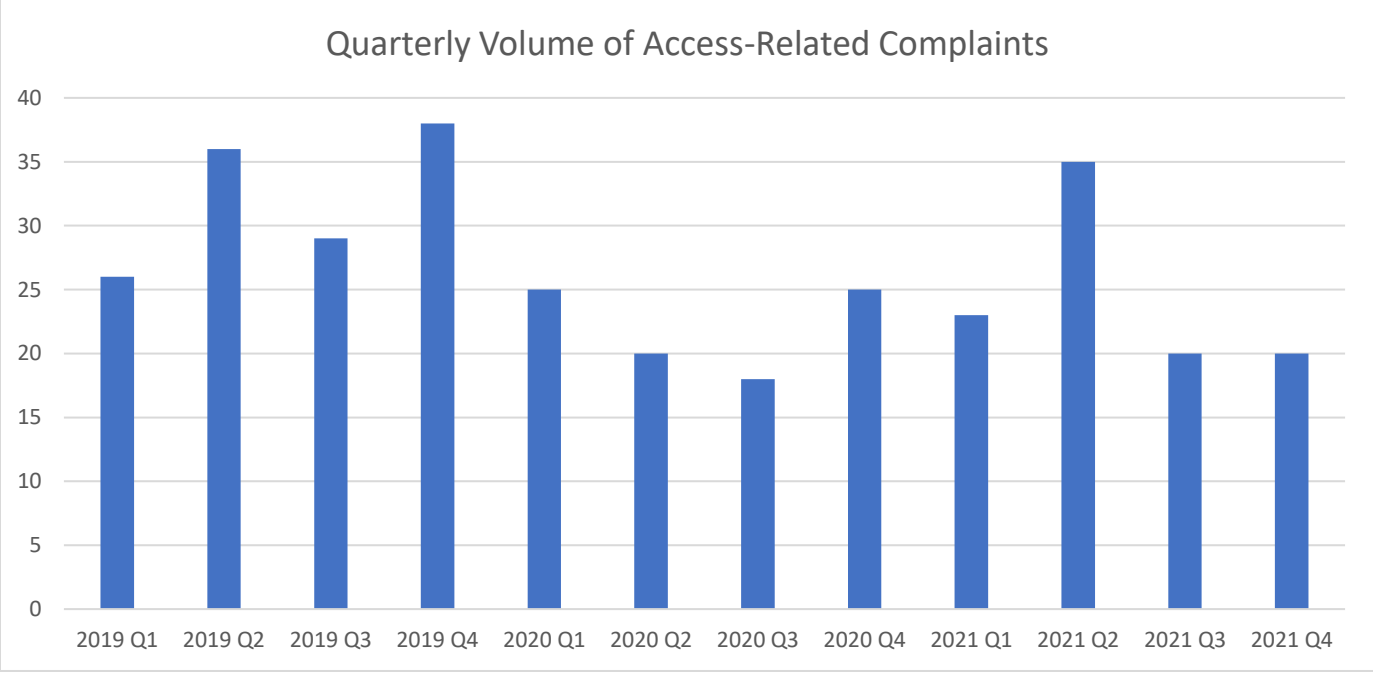
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Advanced Health has undertaken several quality improvement efforts aimed at decreasing the rate of member complaints, especially those related to access and interactions with provider and plan.

Advanced Health has employed a dedicated staff position for the Member Grievance System late 2016. This position is responsible to assist members in accessing the Grievance System, responding to complaints and appeals, monitoring data, presenting analysis, and implementing systemic improvements based on trends in the data. Our current Grievance System Coordinator is an experienced Traditional Health Worker and coordinated care navigator. The Grievance System Coordinator ensures our Member Grievance and Appeals System is responsive to the needs of our members. This person monitors the details of all complaints, appeals, and hearing requests for issues related to cultural considerations and health equity. She participates in the annual Grievance and Appeals audit of our contracted provider organizations.

The Grievance System Coordinator assists in the preparation of our Grievance System Report and Exhibit I deliverables to OHA. This information is also presented quarterly to our Interagency Quality Committee, and bi-annually to our Clinical Advisory Panel. Any trends, and special actions taken, are discussed in the quarterly Grievance System Report submitted to OHA. The PCP Assignment Committee is an interdisciplinary team that specifically works on improving access to PCP services for Advanced Health members.

Some effects from the work from these committees are evident in the decrease of our access related complaints. PCP access is an issue affecting all patients in the region, not just Advanced Health members. In fact, we continue to have better access for our members than patients with traditional Medicare or even commercial insurance. In 2017, access complaints decreased by 25% compared to calendar year 2016. Access complaints decreased by a further 46% in 2018 compared to 2017. And the total decreased by an additional 18% from the 2018 total to the 2019 total. The total number of access complaints decreased again in 2020, by 32%, from 2019. However, some part of that decrease is likely driven by the stay home orders and the overall decrease in utilization pattern since the start of the COVID-19 pandemic response. In Q2 2021 we saw an increase in access all complaints as well as the access category. Our region had a number of retirements, early retirements, and panel changes in that quarter compared to others.

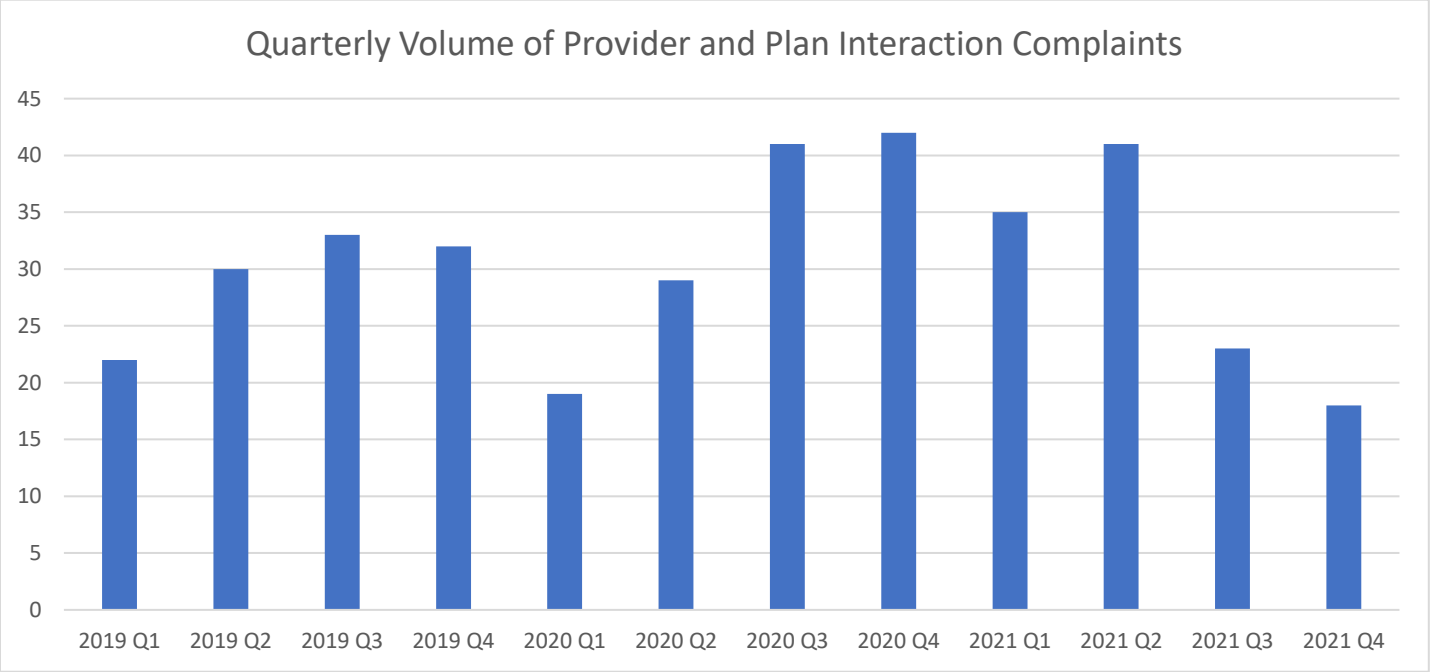


The Grievance System Coordinator works also with our Provider Relations Specialist to review trends and assist provider offices that are generating a high rate of complaints related to patient-provider interactions. Offices are offered evaluation, coaching, and support to improve their interactions with Members. However, in 2020 this process was limited due to the restrictions imposed by the COVID-19 pandemic response. Meetings with providers and their staff were limited to phone calls or virtual meetings and only for the more extreme cases or trends.

There was an increase in member billing complaints in 2021, well over 2019 and 2020 levels, and the category became one of the top three for the first time. In Q2 2021 we performed an in-depth analysis of this data, but no noted trends in source or circumstance were recognized. The results were scattered over the previous 8 quarters. We found instances where members did not provide OHP eligibility information at the time of service; different labs billing members; out of state facilities and providers needing to obtain DMAP ID; and provider office staff retention and training issues. Generally, these issues are easily resolved with contact from our Member Services team leader. In Q4 2021, the lead Member Services Representative identified one in-network provider partner that has hired an external biller. This is a notable trend that will be addressed in early 2022. This information will be presented to our Provider Services Representative for outreach and education.

In addition to reduction in access complaints, Advanced Health saw a decrease in complaints related to interaction of members with their providers. Complaints in this category dropped 20% from 2016 to 2017, and another 37% from 2017 to 2018. The total decreased by an additional 30% from 2018 to 2019. However, this category of complaints rose by 11% in 2020. The reduction in regular feedback to providers and their office staff, discussed above, may be contributing to the increase in complaints in this category in Q3 and Q4 of 2020.

In 2021, after an increase in Q2, we see that this category of complaints has declined to levels similar to 2019.




As a result of this work, Advanced Health had a complaint rate similar to the statewide average during the second half of 2018 and throughout 2019. Advanced Health will continue to monitor complaint capture and resolution processes to ensure members are able to access the system. Advanced Health will also continue to monitor data for trends and offer

feedback and support to delegates, clinics, and individual providers as needed to address member concerns and drive improvements.

The Grievance System Coordinator monitors the details of all complaints twice weekly along with the lead Member Services staff and is working to streamline the process of providing oversight of complaint and resolution information from subcontracted entities. Complaints and appeals are monitored closely for any issues related to obtaining a second opinion, member billing, consumer rights, health equity, and fraud, waste, and abuse. Any trends and actions taken are discussed in the quarterly Analysis of Grievances report submitted to OHA.

In 2020, the Grievance System Coordinator made many improvements to the Grievance System written notices to members. All letter templates were revised and standardized to eliminate potentially confusing language and improve readability and tone, as well as ensuring all required information was included. All letter templates were approved by OHA by late February 2020. Full implementation of all letter templates was delayed by the initial pandemic response (staff and resource priorities redirected) and the time required to adjust staff to working remotely. All the revised letter templates were fully implemented by Advanced Health and its contractors by the end of Q2 2020 Advanced Health will get final OHA approval on our 2021 templates in Q1 2022 and will fully implement changes by August 2022. We have seen a reduction in member appeals due to the improvements implemented mid-2021.

Advanced Health's Grievance System Coordinator participated in the OHA workgroup convened in 2021 to make improvements to NOABD and NOAR templates in particular. Consumer members of the Coos and Curry CACs also reviewed the NOABD template letter and offered their input for changes and helped select from the template options developed by the workgroup.

In 2021, the CACs also received a presentation of grievance and appeal system data. They discussed the grievance and appeal process and the benefits of tracking data for quality improvement purposes.

E. **Brief narrative description**:

While rates for complaints, NOABDs, and appeals have generally returned to pre-pandemic levels in 2021, we have noted some new trends such as the increase in client billing complaints. We also have some potential trends to monitor related to access to the grievance system for members with LEP. Rates of complaints and appeals will continue to be monitored closely and reported to the Interagency Quality Committee quarterly.

Advanced Health staff will also continue to stratify data in the quarterly report to the Interagency Quality Committee by demographic factors to monitor for potential disparities in access or utilization of the Member Grievance System. Due to the higher rate of complaints by members with one or more disabilities, staff will conduct a focused review of those complaints. And the complaint process will be reviewed for potential underutilization by Spanish-speaking members and other LEP members.

The revisions to the Grievance System template letters and member communications in 2021 seemed to have a positive effect and the Grievance System Coordinator continues to receive good feedback from members. Advanced Health will continue to make improvements in 2021. The Grievance System Coordinator will continue to monitor the rate of Appeal Requests per 1000 members and report quarterly to the Interagency Quality Committee. Trends will be monitored to see if the revisions help members better understand the process and the reasons for the CCO's decisions.

In 2022, Advanced Health will implement a cross-training plan to train quality department staff to support the Grievance Systems Coordinator and ensure full coverage for time off. This will improve the capacity and continuity of the member grievance system and will also provide the additional administrative support needed to fully implement the additional reporting and analyis activities.

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

**Activity 1 description**: Grievance System Coordinator will provide quarterly Grievance System reports to the Interagency Quality Committee. Reports will include both quantitative data from the Grievance System and qualitative data from member feedback and observations about the changes to the Member letter templates after they are implemented. The quarterly report to the Interagency Quality Committee will also include data stratified by demographic characteristics including race and ethnicity, language, and disability.

☐ Short term or ☒ Long term

| **Monitoring measure 1.1** | Quarterly trend reports, including data stratified by demographic characteristics, and results of focused reviews, delivered to Interagency Quality Committee. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Quarterly stratified data reports in 2021 | 4 quarterly reports in 2022, including stratified READL data | 12/2022 | 4 stratified reports in 2023, including stratified READL data | 12/2023 |
| No focused review report on rate of complaints by members with a disability | Focused review report complete for 2021 data: complaints by members with one or more disabilities | 06/2022 | Determine need for additional focused review reports based on stratified quarterly data reports | 09/2023 |
| **Monitoring measure 1.2** | Maintain current performance or better on the quarterly rate of member complaints per 1000 member months. (Total number of complaints for the calendar quarter divided by the average monthly enrollment for the quarter times 1000.) This is the complaint rate reported by all CCOs in the quarterly grievance system report. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Current: 3.5 complaints per 1000 members in Q4 2021 | <4.5 grievances per 1000 members | 12/2022 (Q4 2022 rate to be reported in 2/2023) | <4.5 grievances per 1000 members | 12/2023 (Q4 2023 rate to be reported in 2/2024) |
| **Monitoring measure 1.3** | Monitor Appeal rates per 1000 members for changes. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Current: 1.5 Appeal Requests per 1000 members in Q4 2021 | <2.0 Appeal Requests per 1000 members | 12/2022 (Q4 2022 rate to be reported in 2/2023) | <2.0 Appeal Requests per 1000 members | 12/2023 (Q4 2023 rate to be reported in 2/2024) |

**Activity 2 description**: Grievance System Coordinator, Human Resources, and Quality Improvement Specialist will work to develop a cross-training plan to support the additional reporting and review activities.

☒ Short term or ☐ Long term

| **Monitoring measure 2.1** | Develop and implement training plan | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No training plan in place | Training plan developed and mutually agreed upon | 04/2022 | Training plan implemented and complete | 08/2022 |

## A. **Project short title**: Oral Health Integration for Members with Diabetes

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

If continued, insert unique project ID from OHA: 43

## B. **Components addressed**

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

## C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Utilization Review Discussion

Advanced Health maintains a robust system of monitoring and analysis to detect and take action related to over- and under-utilization of services. The process is detailed in relevant written policies and procedures such as the Quality Assurance and Performance Improvement, Utilization Management, and Assurance of Adequate Network Capacity policies and procedures. Much of the monitoring process is carried out through use of internal Tableau dashboards for a wide variety of services, including behavioral health services, COVID-19 vaccination, DME utilization, ED utilization, preventive dental services, SUD services utilization, well child visits, and other utilization-based performance measures. The results of these monitoring efforts are analyzed through various activities such as this TQS report, Delivery System Network report, behavioral health report, care coordination report, quarterly NEMT reports, other routine reports, and ad-hoc reports as needed or requested. The Interagency Quality and Accountability Committee is the primary body responsible for reviewing the analyses of over- or under-utilization. The Clinical Advisory Panel also reviews trends in service utilization, as well as the Community Advisory Council, and the Advanced Health board of directors.

Advanced Health also participated in the MEPP program with OHA Actuarial Services. The MEPP dashboard presents utilization data and potentially avoidable costs for a wide array of episodes of care and service settings. Advanced Health has three projects currently related to data gleaned from the MEPP dashboard. The projects are designed to improve care and health outcomes while also reducing over utilization of costly services. Advanced Health is working on projects to reduce potentially avoidable hospital-related costs for diabetes, asthma, and substance use disorder episodes of care.

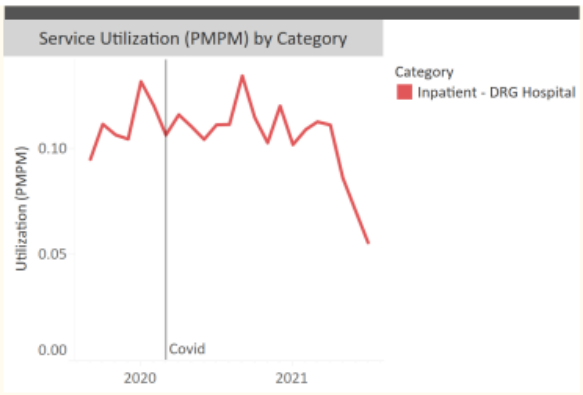
In the 2019 CCO 2.0 Readiness Review performed by Health Services Advisory Group (HSAG), which is the most recent review of Standard XII QAPI, Advanced Health fully met all elements reviewed, including the elements related to mechanisms to detect both under- and over-utilization of services.

Utilization of services was sharply curtailed in 2020 due to the COVID-19 pandemic response, especially dental services as many dental offices closed to all but emergencies in March 2020. Utilization of services across all service types has slowly increased in 2021, but even by the end of 2021 has not returned to pre-pandemic levels. Even after reopening,

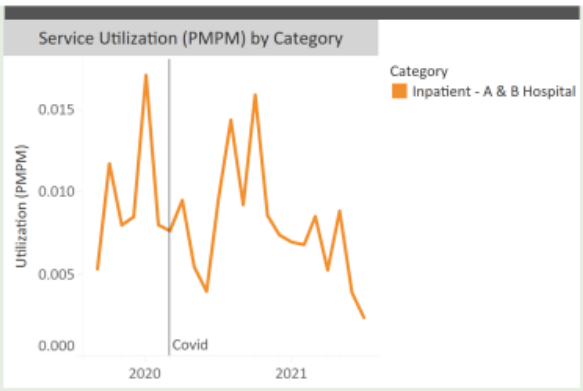
many physical health and oral health services continued to be altered to ensure safety of patients and health care workers, including reduced capacity for routine and preventive services, and adjusting many services to telehealth.

In September of 2021, Advanced Health staff conducted a broad review of the impact of the COVID-19 pandemic response on utilization rates across many broad categories of services. Some of the graphs are shown below. Note the steep decline in the tail of each graph is due to claims data lag. The reports were produced using all available data and did not cut off an ending date of service.

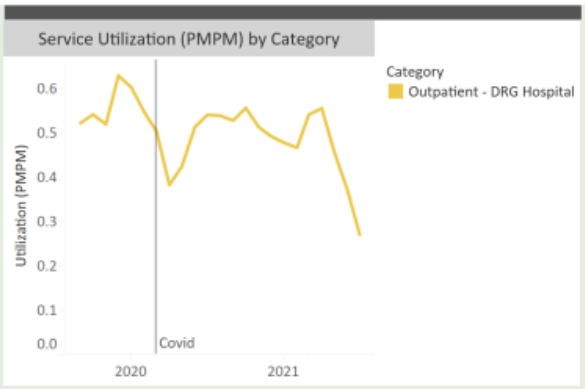
INPATIENT - DRG



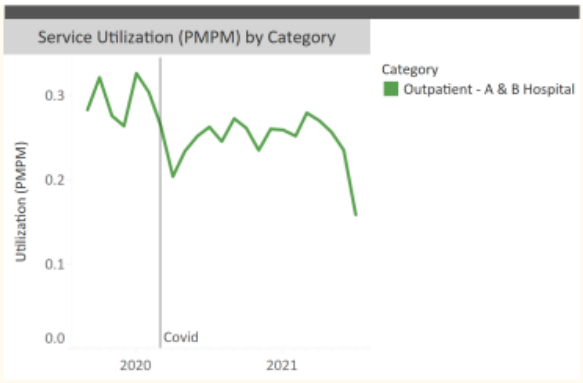

INPATIENT - A&B

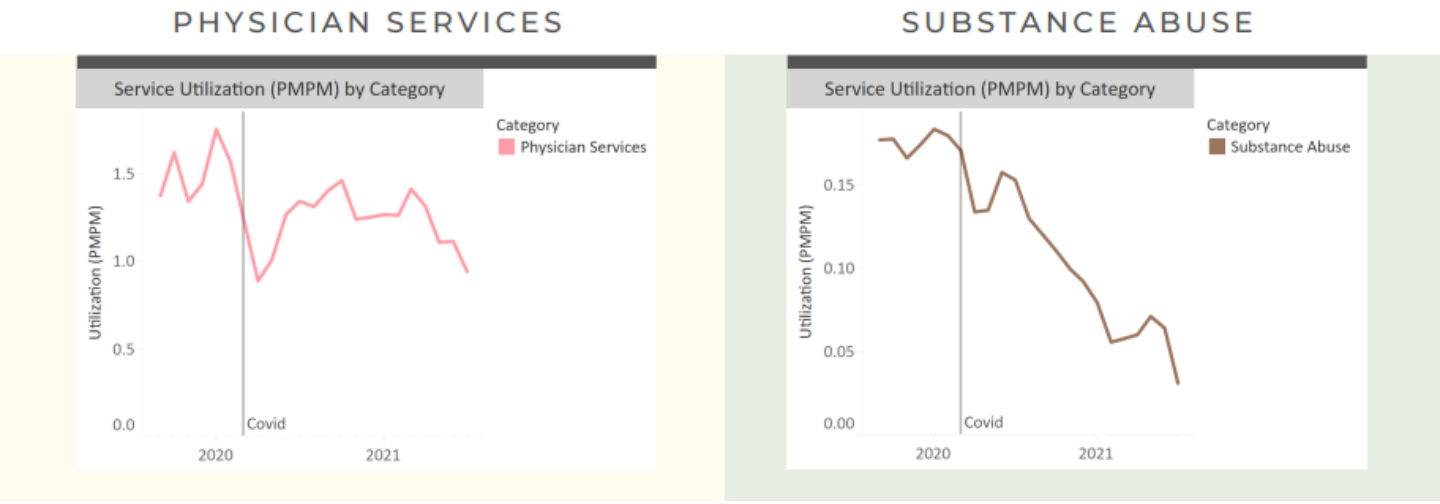



OUTPATIENT - DRG




OUTPATIENT - A&B






The review was an effort to determine which types of service utilization were most impacted and which might be recovering to pre-pandemic levels. Trends were also compared to national data where available, although the relatively small sample of Advanced Health's data and state level differences in pandemic response measures were confounding factors. Further analysis looked at overall utilization trends by vendor across the provider network. In general, most services sharply declined immediately following the initial state of emergency declaration in March 2020, and began to recover somewhat by mid-2020. Some services indicate a plateaued utilization rate in 2021 that is still somewhat below pre-pandemic levels.

The declining rate of SUD service utilization through 2021 (shown in the chart above) is also indicative of an identified billing issue with a subcontracted provider. The billing issue was identified and is being addressed.

Oral health service utilization followed a similar pattern, although many oral health provider offices were closed except for emergencies for several months in 2020. And when they did re-open, services and capacity were limited due to emergency response protocols and staffing shortages. For these reasons, utilization of oral health services remained lower than expected throughout 2020 and into 2021.

<u>Oral Health Integration Discussion</u>

Coos Health and Wellness implemented the Physical Health Integration Team (PHIT) early in 2018 allowing for the integration of physical health services into the behavioral health services setting. PHIT created the ideal structure to support integrating the additional services of an Advantage Dental advanced practice hygienist onto the team and to include a focus on patients with diabetes, as well as severe and persistent mental illness, to improve their access to comprehensive, integrated, whole-person care.

PHIT aimed to make physical and dental health services more accessible to patients, especially those with serious and persistent mental illness, who may not otherwise be well-engaged with the health care system or who were high utilizers of services. The goal was to meet the patients' immediate care needs in a culturally appropriate and trauma-informed setting, while also working to connect patients to their primary care homes and dental homes as needed. According to the CHW program director, both immediate and long-term feedback received from patients and staff was overwhelmingly positive throughout the program and many patients showed a dramatic improvement in their overall health. CHW's high-risk clients established trusting relationships with the PHIT care team over time. Many of the patients they served would just show up to be seen at CHW, without appointments, on PHIT days and the team would work them in. No one was ever turned away. In addition, although 45-minute appointments were originally allotted to give these patients additional time due to communication challenges arising from complex physical and mental health

issues, by the end of the program many did not require 45-minute appointments, often only needing 15-20 minutes due to the caring communication of the team, the trust relationships the team had developed with the patients, and the continuity and consistent easy access to care.

Although PHIT was suspended the end of February 2020 due to lack of funding, because of its overwhelming success and improvement of the participants overall health and quality of life, Coos Health and Wellness's sustainability plan to implement the PHIT team permanently in 2021 has moved forward since our last report. The sustainability plan included the hiring of two full time medical providers and dedicating them two days a week to the PHIT program. By bringing them on full time CHW can re-structure PHIT as an in-house program which will also allow them to bill for their provider services whereas previously the program depended on a contracted provider from a local clinic whom they paid for services without the ability to bill insurance for reimbursement. To-date, CHW has hired one full time medical provider and is in the process of interviewing for a second. Per CHW administration, recruiting the providers has been an arduous process for several reasons which include the rural location within the state and our current housing crisis, as well as the ongoing pandemic-related challenges which continued throughout 2021 and into 2022.

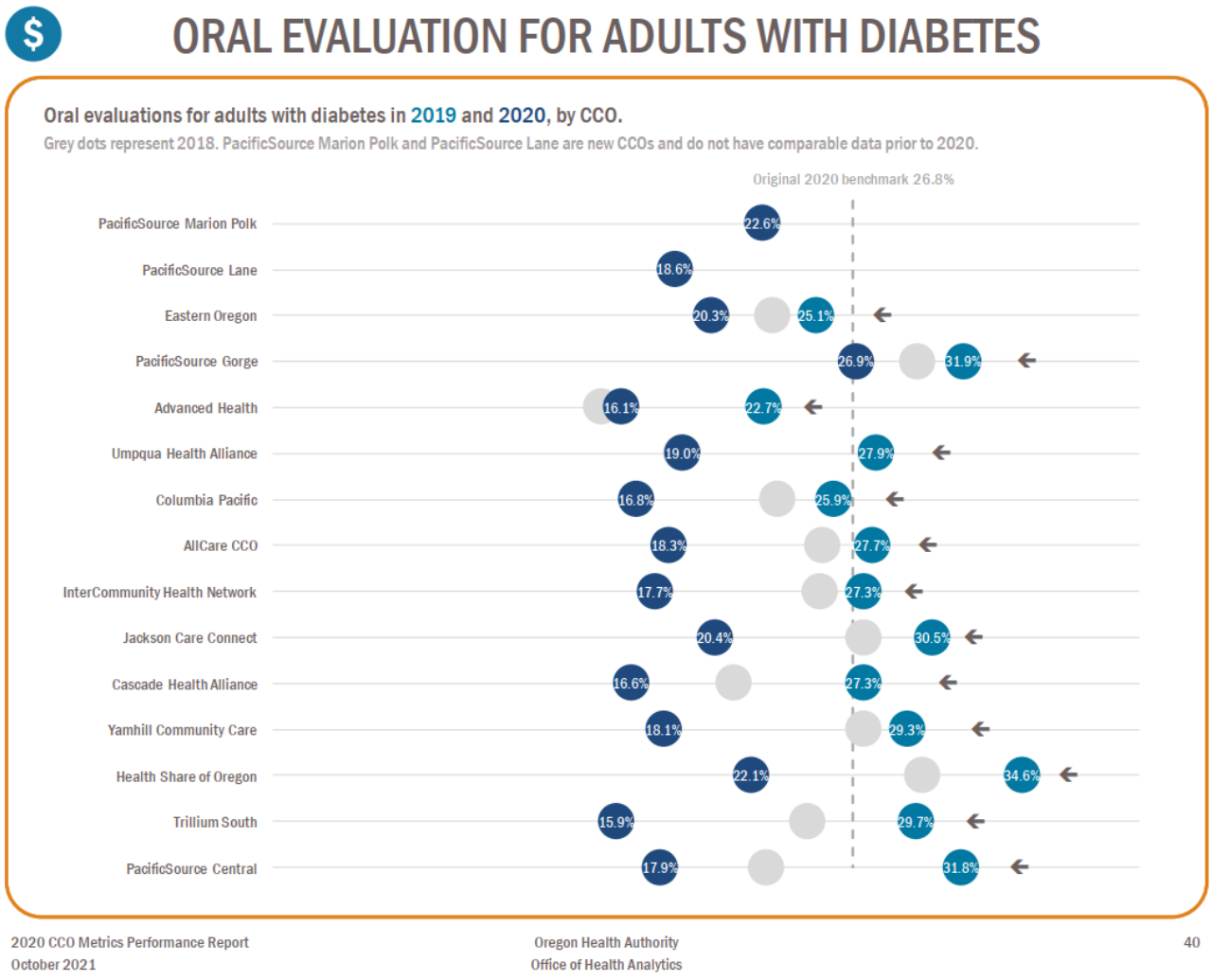
CHW has also worked with Advantage Dental over 2021 to increase access to their advanced practice hygienist from seeing patients onsite at CHW for a minimum of two days a month and once a week during the summer months, to a minimum of being onsite one day a week, or 4 days a month, with plans to be onsite additional days a week during the summer months. This has helped to increase much-needed oral health care to an underserved and at-risk population which includes those with a diabetes diagnosis as well. The Advantage Dental expanded practice dental hygienist also helps patients in need of further dental services get connected with their primary dental care home and Advantage Dental case management services as needed to improve the overall utilization rate of oral health services.

One of the greatest advancements for oral health integration in our network in 2021 was the successful integration of an Advantage Dental advanced practice hygienist at a total of six of our Primary Care Clinics, including our two largest clinics, with both onsite basic dental services and telehealth services with a dentist being offered at all participating sites which includes the following: Bay Clinic, North Bend Medical Clinic (NBMC), Waterfall Clinic, Coos Health & Wellness, and both Coast Community Health's Bandon and Port Orford clinic sites. The successful advancement of integrated services at these sites has greatly improved access to our members and there has been a concerted effort to schedule diabetic patients/members onsite by their care teams, as well as offering diabetic health fair/outreaches in which the advanced practice hygienist is available to see diabetic patients/members in attendance.

Utilization of Oral Health Services by Members with Diabetes

Although much improved from 2020, Advanced Health continued to have a relatively low rate of oral health assessments for members with a diagnosis of diabetes in 2021. The state-wide benchmark for this measure in 2021 stayed the same as the 2020 state-wide benchmark of 26.8%. The 2021 benchmark was selected by the OHA Metrics & scoring Committee and 2020 was set at 26.8% based on the 2018 CCO 75th percentile, although 2020 was a reporting year only due to the pandemic emergency response. Advanced Health's 2018 rate was 15.2%, 2019 performance rate was 22.7%, and 2020 performance was reported at 16.1%. Most our advances made to improve coordination and utilization of oral health assessments for members with a diagnosis of diabetes were lost in the first year of the pandemic emergency response, with the 2020 performance data showing a significant decrease of 6.6 percentage points from 2019 performance. Further, Advanced Health's 2020 performance data reflects only at 0.90 percentage points higher than 2018 performance data and remains well below the 2020/2021 state-wide benchmark of 26.8%.

The chart below is from the 2020 CCO Metrics Performance Report published by OHA in October 2021. This is the most recent report available with a full measurement year of data. This report compares 2020 performance to the previous two years and compares performance across all CCOs.




2020 CCO Metrics Performance Report
October 2021

Oregon Health Authority
Office of Health Analytics

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Due to a community wide EHR conversion to Epic at the two largest primary care clinics and largest hospital in our provider network, as well as Advanced Health's implementation of a new internal claims processing system, internal preliminary CY 2021 data is not currently available to us. However, the most recent data available from the OHA 12 Month Rolling Dashboard for October 1st, 2020, through September 30th, 2021, shows a rate of 19.0% which is an encouraging increase of 2.9 percentage points over 2020 final performance rate of 16.1%. Thus, Advanced Health recognizes, although seeing improvement in 2021, the ongoing need for improvement to ensure appropriate level of service utilization for oral health assessments for members with a diagnosis of diabetes. A key strategy to improve utilization is to promote integration of oral health services through data sharing, improved referral pathways, and access to oral health services in primary care and behavioral health care settings.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Evidence shows patients with diabetes who have good oral health care have improved HbA1c blood sugar control. In turn, diabetic patients with better controlled HbA1c levels have better outcomes for their oral health care. Periodontal disease outcomes and diabetic health outcomes are linked. To this end, early in 2018 Advanced Health sponsored a collaborative quality improvement project between Advantage Dental and Coos Health and Wellness. It was implemented to make dental assessments more accessible to patients with severe and persistent mental illness (Advanced Health contracts dental services to Advantage Dental and behavioral health services in Coos county to Coos

Health and Wellness (CHW)). Through this collaborative project an Advantage Dental advanced practice hygienist provided dental assessments for clients engaged with behavioral health services at CHW. Advantage Dental seeks to provide services to vulnerable populations in a setting which is more comfortable to the patient by increasing participation in screenings and prevention in the community setting. The Advantage Dental risk-based care and medical management strategy, when employed in the community setting, reduces barriers to access, allows for identification of emergent oral health issues and establishes a care coordination pathway for individuals to receive needed care and prevention services. The partnership with CHW and Advantage Dental provided an opportunity to serve individuals in the environments in which they are already comfortable, which was critical for the patient population being targeted.

Starting in January 2019 Advanced Health created gap list for Advantage Dental with members with diabetes who needed to be seen by their dental providers. Advanced Health sent this monthly gap lists to Advantage Dental from January 2019 through June of 2019. Starting in November of 2019 Advanced Health began resending the diabetic member monthly gap list to Advantage Dental with the agreement to continue to do so indefinitely. The gap in list distribution was due to staff transitions. During this time Advantage Dental developed a proactive workflow where they used the gap list to schedule diabetic members as soon as possible and tracked the members' appointments to ensure they were kept and rescheduled if needed.

In September 2019 Advanced Health, added an oral health indicator to the primary care provider member-level diabetic A1C gap lists. This indicator identified if the member had received an oral health exam in the calendar year. This indicator was identified as high value as a point of care outreach and referral guide by the Interagency Quality Committee.

The COVID-19 pandemic negatively impacted progress on this oral health integration TQS project in 2020. Advantage Dental had a significant decrease in access to and utilization of oral health care for CCO members in Coos and Curry County. Primary care providers directed resources to the frontlines of patient care with providing emergent and telehealth services. Work and progress on the Oral Health transformation strategy was re-prioritized in 2021 and great strides were made despite the ongoing challenges created by the pandemic.

The original plan prior to COVID-19 was for Advanced Health to be responsible for sending member gap lists out monthly starting in mid-March 2020 once initial 2020 claims data becomes available. The initial goal was to have new processes in place by April 2020 and for all participating clinics to be able to meet the upcoming new Patient Centered Primary Care Home Oral Health Services Standards 3.F.1 and 3.F.2 before the end of 2020. This project timeline was moved to 2021 to decrease the burden on the provider network which is still managing the COVID-19 pandemic response. Over 2021 all our primary care clinics reengaged in working the oral heath diabetic gap lists and began conducting warm hand offs, as able, by making dental appointments for their diabetic patients by working with Advantage Dental case management in real time, while patients are onsite at the clinics being seen by their primary care providers. Diabetic patients/members appointments are now leaving their PCP appointments with Advantage Dental appointment cards in hands when warm hand-offs occur.

### E. **Brief narrative description**:

Advanced Health will continue to work with Advantage Dental, the primary care provider network, and behavioral health providers to create pathways for better information sharing, care coordination and integration for shared patients with diabetes. This means that both PCP clinics and Advantage Dental will receive reports and gaps lists of diabetic members in need of dental appointments. PCP clinics will work directly with Advantage Dental Care Coordinators, who can be reached by calling a single number, to schedule patients in real time during their PCP visits. With the more complete dental visit information available to PCP offices, they will be able to more effectively coordinate appointments such as diabetic oral health exams, annual checkups and cleanings, urgent dental needs, and sealants for pediatric patients. The Interagency Quality Committee will continue to work together to refine the process for

scheduling members identified as needing appointments with their dental providers and clinic-specific processes for working the gap lists.

In addition, our largest primary care clinics are working directly with Advantage Dental to create an effective workflow to close the referral loop and ensure patients/members, and members with a diabetic diagnosis, have indeed been seen in a timely fashion and their PCPs are aware of the outcomes. These two largest clinics provide PCP services to approximately 70% of Advanced Health members. This has been a challenge especially during the ongoing pandemic, but we are hopeful to have a viable and working solution in place before the end of summer which can be spread to all primary care clinics within in Coos and Curry County by the end of 2022.

As a long-term strategy, Advanced Health continues to work with Advantage Dental and local dental providers to offer education to all local primary care providers with the consistent messaging on the benefits of regular oral health evaluations to patients with chronic diseases, especially diabetes. Also of note, newly developed co-branded educational materials targeting our diabetic members was developed by Advanced Health and Advantage Dental over 2021 and successfully distributed to our members and primary care clinics over the last quarter of 2021. Consistent educational messaging continues to be an important strategy in reaching our diabetic members regarding the importance of their oral health and fully supported and promoted by all our primary care clinics.

Despite the negative impact of the pandemic on utilization of oral health services, in partnership with our primary care clinics and Advantage Dental, we are pleased to see the advancement of our strategies, especially the successful integration of advanced practice hygienists within our main primary care clinics, is having a positive impact in reaching our diabetic members and ensuring they have easy access to oral health care. Further, Advanced Health continues to explore additional opportunities to integrate care, especially for vulnerable populations such as those with serious and persistent mental illness and will continue to analyze available data and monitor throughout the course of the performance improvement projects for potential health disparities which need to be addressed through additional or modified intervention as well.

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

**Activity 1 description**: Create, validate, and disseminate reports and educational materials as requested by the Interagency Quality Committee, provider offices, and Advantage Dental case management to support data sharing, integration of oral health services and referrals, and to increase utilization of services to improve health outcomes.

☐ Short term or ☒ Long term

| **Monitoring measure 1.1** | Monitor milestones in the process to create, validate, and routinely disseminate reports. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Oral Evaluation status provided to PCPs for members also meeting denominator criteria for A1c Poor Control quality measure | Provide Oral Evaluation status to PCPs for all members meeting the denominator criteria of the Oral Health Evaluations quality measure | 04/2021 | Provide monthly updates of Oral Evaluation status to PCPs for all members meeting the denominator criteria of the Oral Health Evaluations quality measure | 12/2022 |

| **Monitoring measure 1.2** | Milestones for the process of developing and disseminating educational materials. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No or little patient education materials related to oral health available in PCP settings. | Standardized, targeted patient education materials related to oral health available in 40% of primary care offices in our network | 3/2022 | Standardized, targeted patient education materials related to oral health available in 100% of primary care offices in our network | 12/2022 |
| **Monitoring measure 1.3** | Monitor performance on the Oral Evaluations for Adults with Diabetes quality measure with a goal of returning to 2019 performance in CY 2022 and improving by 2 additional percentage points in CY 2023. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 16.1% of adults with diabetes receiving an oral evaluation (2020 performance)<br><br>19.0%<br>Current performance data available (Oct 2020 through Sept 2021) | 22.9% | CY 2022 (Final report available 06/2023) | 24.9% | CY 2023 performance (reported in 06/2024) |

**Activity 2 description**: Form a subcommittee/workgroup of the Interagency Quality Committee with engagement from participating clinics and Advantage Dental to develop a closed loop referral process between primary care practices and Advantage Dental practices.

☒ Short term or ☐ Long term

| **Monitoring measure 2.1** | | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No subcommittee or workgroup established | Subcommittee workgroup established | 08/2022 | Subcommittee develops a closed loop referral process to pilot. | 12/2022 |

A. **Project short title**: Community Collaborative – Initiation and Engagement in SUD Treatment

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

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

## C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Behavioral Health Integration Discussion

Prior to 2020, Advanced Health CCO partnered with the local County Mental Health Program (CMHP) for primary management and service delivery of all mental health related services. Members were required to be an "open client" with the CMHP with a full behavioral health assessment and treatment plan prior to being eligible for mental health services. Advanced Health underwent a major transformation in Behavioral Health services in 2020, which paved the way for services to be contracted with multiple providers rather than delegating all services to the County Mental Health Provider (CMHP). Advanced Health continues to contract with the local CMHPs while also expanding the provider network to include individual behavioral health providers and integrated behavioral health providers co-located in primary care and specialty clinics. This shift provided expanded and increased access to Behavioral Health services for all members, and particularly for those with serious and persistent mental illness (SPMI).

The service expansion created foundational changes to services to include:

- New contracts with local mental health providers allowing a broader network for Members to choose from.
- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

Integrated behavioral health has been contracted in four primary care clinics, serving approximately 80% of Advanced Health members, allowing members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs once a member has been identified as needing additional behavioral health or substance abuse services. Advanced Health continues to accept applications to enter the network from providers who meet credentialing standards.

Advanced Health welcomed two new staff members to the behavioral health team as director and manager. They embarked on a listening tour throughout the service area to engage with providers, community-based organizations, and social service agency partners in the community. The goal was to learn from them what they needed for support, how their organizations functioned and partnered with other programs, what they felt their strengths were and how they benefitted our communities, barriers that needed to be addressed, and success stories. These listening sessions proved invaluable for all involved. Great relationships are being built and all are focused on bettering our delivery of care to our members.

While meeting with our integrated behavioral health teams in the surrounding clinics we heard just how important this role has been in both strengthening the alliance of the physical wellbeing with mental health. Our local primary care

providers lean heavily on our behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively. The partnership is fantastic and valued by the professional team as well as our members who have a warm hand-off and timely access to behavioral health care within the same visit.

An EHR transition to Epic was successfully rolled out in 2021 in our largest regional hospital, Bay Area Hospital, as well as with our two largest area clinics, both of which offer integrated behavioral health services. This EHR platform will improve patient and member treatment and ultimately outcomes as information and plans of care are easily shared among providers. Work is continuing to allow all organizations, no matter their health record platform, access to EPIC. This will enhance electronic data sharing and improve coordination across the entire care team.

Timely Access Discussion

One of the primary vehicles for Advanced Health to evaluate timely access is through the annual Delivery System Network (DSN) narrative report submitted to OHA for review. The DSN report includes a comprehensive evaluation of time and distance standards as well as a discussion of timely appointment access standards. The 2021 DSN report was submitted to OHA in August 2021.

When evaluating Advanced Health's compliance with time, distance, and access standards it is important to note that the entirety of Advanced Health's service area is rural. The largest population center is the combined North Bend/Coos Bay area, located in Coos County. Coos Bay has a population of just over 16,000 and North Bend has a population of just under 10,000. Together, North Bend and Coos Bay make up a population center of approximately 26,000. Advanced Health has not calculated or submitted data related to the urban time and distance standards because they do not apply to our service area.

The population centers of Coos and Curry Counties (Coos Bay, North Bend, Bandon, Coquille, Brookings, and Gold Beach) are located such that most of the outlying population is within a 30 minutes' drive, or approximately 20 miles.

OHA manages the process of enrolling and assigning members to CCOs. Advanced Health, nor any other CCO, has the ability to enroll members onto the Oregon Health Plan or to assign members to a specific CCO. Sometimes these processes of enrollment and assignment can take some time to catch up when a member moves into or out of the area and Advanced Health finds a number of members at any given time with addresses that place them outside the Advanced Health service area. For these members living outside of Coos and Curry Counties, the Advanced Health network providers will be outside the time and distance standards. There are no meaningful provider network improvement actions that Advanced Health can take to address time and distance compliance concerns for these members.

Some of the more challenging aspects of ensuring 100% compliance with time and distance standards are discussed above, including the OHA enrollment and assignment process, the geography of the region, and location of population centers (and therefore providers) in relation to individuals living in remote areas. Advanced Health is committed to the process of continuous improvement and works closely with local providers and community partners to develop creative and transformative solutions to these and other complicated issues facing health care delivery in rural Oregon, and on the Southern Oregon Coast in particular.

Advanced Health details expectations related to wait times for all appointment types in the *Advanced Health Provider Manual,* the *Covered and Non-Covered Services Policies and Procedures* as well as in contract language. Advanced Health's process for contracting and for services and monitoring contract performance is detailed in the Advanced

Health *Contracting Policies and Procedures Manual*. Advanced Health also monitors data from the Grievance and Appeal system and survey data such as CAHPS to assess access to care, including wait times for appointments with all provider types.

Advanced Health has noted a significant downward trend in primary care access-related complaints since 2017. The number of access complaints in 2018 was 45% lower than in 2017. And the number of access complaints in 2019 was 17% less than in 2018. Data from 2020 continued this trend, but the cause of the decrease in 2020 is more likely the result of the limitation of services and stay home orders issued in response to the COVID-19 pandemic. The actions taken to improve members' experience of access to care are discussed in more detail in Element 7 of this report.

Locally, the wait time for non-urgent medical specialty appointing is very reasonable. If the matter is more urgent, the local community of medical specialty physicians is always willing toaid referring primary care providers by granting early access, even if it means that the medical specialist extends his or her workday. There is a spirit of collegiality among the members of SWOIPA and they work actively to lend aid and assist one another.

Wait times for out-of-area medical specialty appointing will be a little longer, but not unreasonably so generally accepted practice standards, although some patients may experience the wait times as being "too long," (albeit whenever anyone is waiting for worrisome diagnostic test results, even hours, let alone days, feels "too long"). In truth, wait times are reasonable and in keeping with community norms, apart from neurology where wait times can be six months for a non-urgent consultation.

Wait times are monitored informally in real time. Because we have close relationships with our provider network, staff call when local wait times are unreasonable, usually due to limited supply in that specialty. When this occurs, medical management staff approve referrals to out-of-area specialists as appropriate.

In several high-demand specialties, our specialists have noted that many of the referrals they receive have not been optimally evaluated by their PCP. To ensure the most high-value visits to those specialists, and to improve capacity for those enrollees who truly need the specialists' services, Advanced Health staff have worked with those specialists to develop "Readiness to Refer" tools. Beginning with gastroenterology and hepatitis C, our care management staff worked with the specialty offices to develop checklist tools to guide the PCP. That way, initial steps can be handled locally by the PCP who has a working relationship with the patient. Once the preliminary steps are done, the tool can also serve as a checklist to ensure that staff provide all the pertinent information when making the referral. The readiness tools have been very well received by PCPs, who have suggested some additional specialties be added. The specialists are pleased to use their precious time on patients who are appropriately selected for referral. We currently use readiness tools for gastroenterology/hepatitis C, urology, ophthalmology (to differentiate medical eye from vision), and bariatric surgery.

Technology has made it temporarily more difficult to conduct "secret shopper" evaluations of wait times. Referrals are placed electronically, so specialists' office staff do not expect to offer appointment times to enrollees calling without a referral from the PCP. To date, Advanced Health has not had access to data sources to directly and effectively assess timely access standards. This has been due to the lack of capability of the disparate electronic practice management and medical record softwares used throughout the provider network sectors. In 2020, the CCO provided a significant financial contribution towards the implementation of EPIC, involving the regional hospital and several of the largest primary care and specialty provider clinics, representing a significant proportion of the provider network. These organizations provide the majority of hospital, primary care (adult and pediatric), OB/GYN, and integrated behavioral health services, as well as a large proportion of specialty services. Implementing an EPIC system across several organizations throughout the community in this way yields many benefits, one of which is expected to be improved transparency and reporting around timely scheduling and access to services.

Advanced Health received a 97% compliance score for the Description of the Delivery Network and Adequacy portion of the DSN report, which includes the Time and Distance analysis, discussion of timely access to appointments for various types of services, and monitoring the provider network.

As part of the 2021 Compliance Monitoring Review activity, Health Services Advisory Group (HSAG) reviewed the Availability of Services standard for Advanced Health. Advanced Health received four findings related to the communication of timely access requirements for physical health, oral health, behavioral health, and specialty behavioral health, including substance use disorder treatment. HSAG found that while the information on timely appointment access was stated correctly in the policies and procedures and in the provider manual, the information was not included in the Member Handbook. Advanced Health's 2022 Member Handbook includes information about all the state standards for appointment time frames. This direct communication to members about when they should expect to schedule an appointment is a valuable tool for member empowerment to be an advocate for their timely access to care

Timely Access to SUD Treatment

The tables below are excerpted from the 2021 DSN report and show the results of Advanced Health's drive time and distance analysis for adult primary care, behavioral health care, and substance use disorder treatment. The rural drive time standard is 60 minutes and 60 miles. Advanced Health uses member addresses and provider addresses to calculate actual drive time and drive distance. The tables below show the average time in minutes, the average distance in miles, and the percentage of members who are within the 60 minute/60 mile time and distance standard.

| | Average Time (m) | Average Distance (mi) | Percentage of Members |
|---|---|---|---|
| **Adult Primary Care Provider (PCPA, PCPB)** | 21.4 | 15.1 | 94.8% |
| **Adult Mental Health Provider (MHPA, MHPB)** | 22.6 | 16.2 | 93.5% |
| **Adult Substance Use Disorder Provider (SUDPA, SUDPB)** | 30.0 | 22.0 | 88.2% |

From the analysis above, we can see that members have good access to PCP and behavioral health services with the average time to reach the nearest providers office at just 21 or 22 minutes (60 minutes standard) and 15 or 16 miles driving distance (60 miles standard). For substance use disorder treatment providers we observe that the average time and distance are longer, and the percentage of members within the 60 minute/60 mile standard is less as well.

Advanced Health contracts with Southwest Oregon Independent Practice Association (SWOIPA) for the services of it physical health, mental health, and SUD treatment panel; in turn, SWOIPA contracts with nearly every practicing physical and behavioral health provider in Coos and Curry County and several outside the counties. There are a handful of providers in the area who choose not to accept any insurance or who choose not to accept Medicaid or Medicare patients. Therefore, there are very nearly as many primary care, behavioral health, and specialty providers to meet the needs of the Enrollee population as there are to meet the needs of the general population.

For all substance use disorder treatment services except medical detoxification, SWOIPA contracts with ADAPT, Inc. ADAPT maintains home offices in Roseburg (Douglas County), and full-service out-patient services in Reedsport (Douglas County), Grants Pass (Josephine County), and North Bend (Coos County). ADAPT, in turn, contracts with Curry Community Health for the provision of out-patient treatment services. Within Coos and Curry Counties, ADAPT either directly employs, or contracts for the services of Certified Alcohol and Drug Counselors (CADCs). ADAPT responds to urgent needs on a 24/7 basis.

ADAPT operates residential treatment programs in Roseburg for adults, women with infants, and adolescents, and these services are made fully available to Advanced Health's enrollees according to American Society of Addiction Medicine (ASAM) criteria. Social detoxification services are also available in Roseburg, and any non-covered NEMT services are arranged, as needed, on a case-by-case basis.

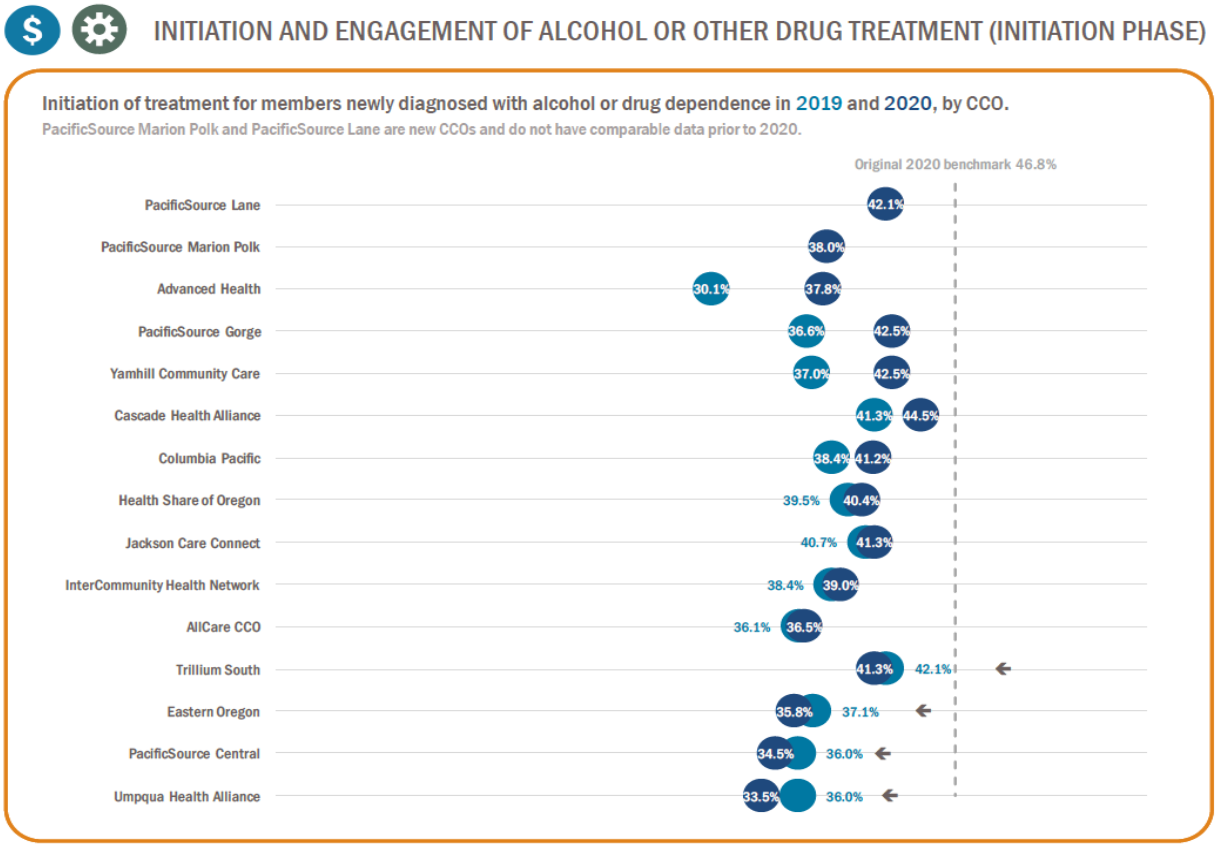
To address either provider shortages or issues of time and travel, ADAPT offers telemedicine services to make the services of prescribing physicians available to patients who are being treated for substance use via medication-assisted treatment.

In May of 2020, as part of Advanced Health's response to the COVID-19 pandemic and the subsequent restrictions placed on in-person services, the Board of Directors authorized a Telehealth Access Fund. All local in-network providers were invited to apply for funds to quickly increase the availability of and improve access to telehealth services to meet the needs of Advanced Health members. Project proposals were reviewed by the Clinical Advisory Panel for final funding determination. Funds were awarded to 10 different provider organizations within the Advanced Health network. Funding awards were split between counties with approximately 10% of funds going to providers in Curry County and 90% to providers in Coos County. Advanced Health diligently recruited applicants from the behavioral health network and was pleased to be able to award approximately 41% of the funds to behavioral health and substance use treatment providers. Another 51% of the funds were awarded to PCPCH recognized clinics with integrated behavioral health available to patients. The remaining 8% of funds were awarded to physical health only providers and organizations.

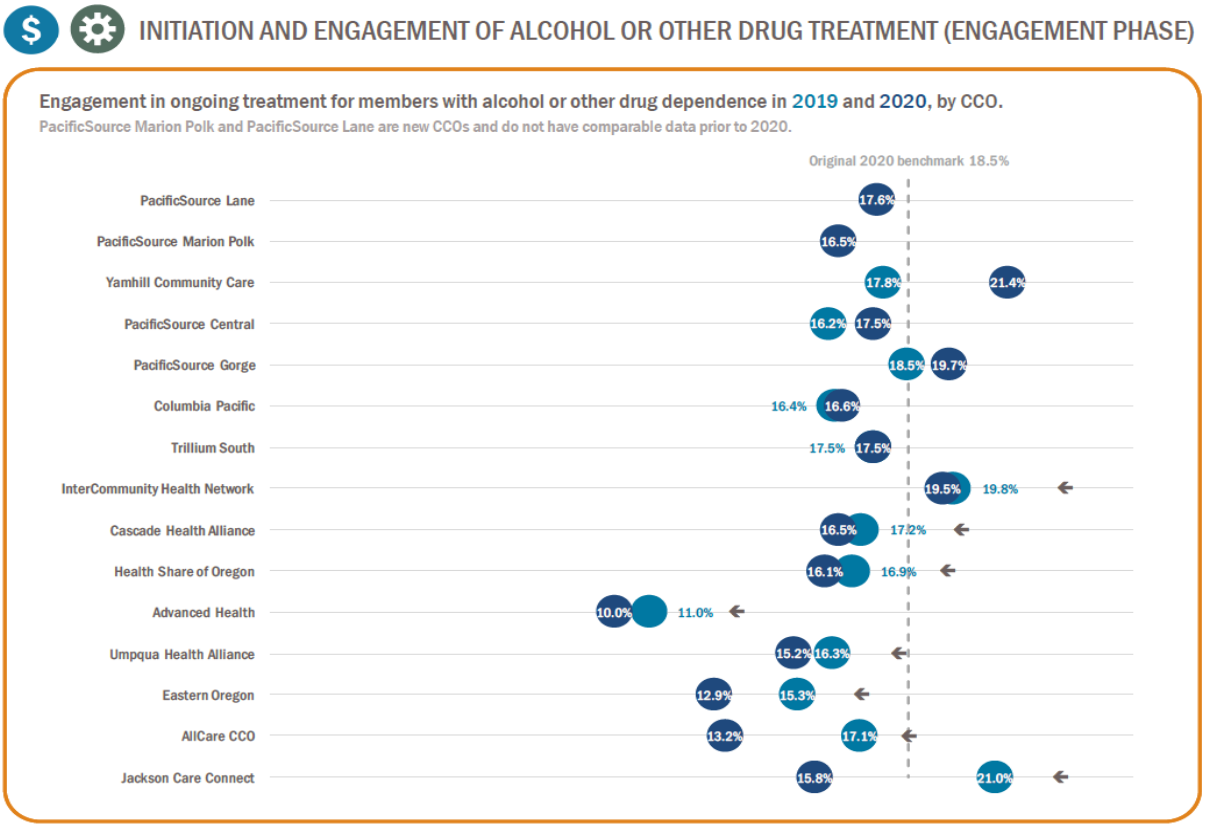
Initiation and Engagement in SUD Treatment Measure Performance Discussion

Initiation and Engagement of Alcohol or Other Drug Treatment was a new Coordinated Care Organization Quality Incentive Measure in 2020 that is comprised of two components ensuring access to care for initiating and engaging in treatment. Historically, Advanced Health has had a low performance rate compared to statewide performance:

Initiation: The statewide benchmark for initiation in 2019 was 42.1 Advanced Health's performance was short at 30.7%. In 2020 the statewide benchmark for Initiation increased to 46.8% and Advanced Health's performance increased significantly from 30.7% in 2019 to 37.8% in 2020. The results from the 2020 CCO Quality Measures report is included below. This is the most recent year for which full performance data is available.




Engagement: The statewide benchmark for engagement in 2020 was 18.5% with a statewide average performance at 16.2%. Advanced Health's performance declined from 11.0% in 2019 to 10% in 2020. The results from the 2020 CCO Quality Measures report is included below.




Annual report data reveals that while we improved in initiation of treatment, performance remains below the benchmark for the state. In addition, the rate for engagement continues to decline from previous year performance. Advanced Health's role will be focused on improving processes that ease member navigation through the system, build lasting relationships with peer supports and other caregivers and use motivational interviewing to help alleviate barriers increasing the likelihood of members success.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Advanced Health's low performance rate for the Initiation and Engagement in Alcohol and Other Drug Treatment quality measure has been an ongoing concern for the Advanced Health Interagency Quality Committee. The Interagency Quality Committee includes representatives from Behavioral Health, Non-Emergent Medical Transportation, Oral Health, Physical Health (Adult and Pediatric), and Substance Use Treatment provider organizations. All four clinics with integrated behavioral health services are represented on the Interagency Quality Committee.

The point of concern identified by the Interagency Quality Committee around timeliness regarding Initiation and Engagement in Alcohol and Drug Treatment (IET) was due to low performance on the quality measure despite all the work that had been done in the past several years around changing opioid prescribing habits, SBIRT screening and referral processes implemented in primary care homes in 2015, and Adapt (and Advanced Health contracted SUD treatment provider) opening the doors to their new "Fresh Start" day treatment and supportive housing facility in March of 2017. According to ADAPT's 2018 Annual Report, 424 patients were treated within their MAT Opioid Treatment Program alone in 2018. These delivery system network changes to increase SUD treatment capacity, reduce travel time and distance, and reduce appointment wait times had not shown a corresponding improvement for initiation and engagement in treatment.

While discussing Initiation and Engagement to Alcohol and Drug Treatment metric requirements for 2020, the Interagency Quality Committee highlighted barriers among the provider network system to include incentive quality metric specification complexity, workflow training complexity to providers and staff, lack of structured referral pathway system, gaps in care due to referral loop closure pathways and lack of understanding around the additional documentation required for privacy requirements related to substance use treatment (42 CFR requirements). Another barrier identified is the inability for the CCO to provide proactive data to support work being done at point of care due to the reactive process of relying on claims data to identify the triggering events. By the time the claim passes into the system for reporting, the opportunity for taking timely action has already passed. The Interagency Quality Committee recognized that due to the complexity of the metric, Advanced Health was unlikely to achieve improvement targets if work remained isolated within individual provider organizations.

Advanced Health offered to sponsor a lean training Kaizen event and asked the Interagency Quality Committee to direct the focus of the training. After multiple meetings with discussion around workplan focus, the Interagency Quality Committee identified three potential areas of collaborative work: 1) ED Utilization/ ED Navigator/ Community Education, 2) Diabetic Oral Health- a community workflow, or 3) Initiation and Engagement of Alcohol or Other Drug Treatment – a community workflow. The Interagency Quality Committee then voted anonymously via Survey Monkey and ranked their preference for the lean training event project focus. The Interagency Quality Committee voted to concentrate group efforts towards a LEAN training/Kaizen event focused on the 2020 quality incentive measure, Initiation and Engagement of Alcohol and Other Drug Treatment. The committee deemed the work to be aligned with Patient Centered Primary Care Home (PCPCH) 5 Star designation requirements related to coordination of care and cooperation with community service providers.

Alongside Patient Centered Care Homes, this work also aligns with the priorities identified in the Advanced Health Community Health Improvement Plan, approved by the Community Advisory Council, by supporting individual prevention services and improving access to integrated services and delivery of addiction services as priority areas.

The training was intended to be facilitated in the spring of 2020, but due to the onset of the COVID-19 pandemic, was put on a temporary reschedule hold for the fall of 2020. The training was further postponed to the fall of 2021 due to key stakeholders undergoing a community-based Electronic Health Record implementation and continued safety precautions and travel restrictions as a result of the COVID-19 pandemic. Unfortunately, mid 2021 brought with it the realization that the Kaizen event was not going to come to fruition as COVID-19 mandates remained in effect longer than anticipated and both Delta and Omicron variant surges further stressed the local health care system's ability to engage in time-intensive improvement projects like the week-long Kaizen event training.

That said, this initiative remains a high priority for the Interagency Quality and Accountability Committee who met in September of 2021 to discuss the project's need for a reboot and to explore other interventions. The Interagency Quality Committee agreed that this training was most valuable to them in person and the ongoing pandemic response and limits to in person events has made this impossible. The committee requested that Advanced Health conduct data analysis using Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) metric to determine the main source of referrals for treatment and to shift the focus to better understanding barriers for referral and follow up treatment given the current referral pathways.

This evaluation was done in October 2021 using 2020 full year data as it was the most comprehensive data set available at the time. Data analysis revealed that 40 percent of index diagnoses were generated from primary care and only 15 percent from substance use providers. The committee identified the need for a process to assist in the patient transition from diagnosis in the primary care setting to treatment and how leveraging either peer support specialists or existing Integrated Behavioral Health teams could aid in the process. The Committee identified key points around building trust relationships to encourage members to start treatment and how the peer support role was appropriate.

This intervention aims to increase timely access to treatment using the warm hand-off model of care to behavioral health staff who can engage the member using techniques to assist them in understanding the pathway to treatment. Since established integrated behavioral health teams will be leveraged to do this work, the access to services for the member in this aspect of the process can be almost instantaneous. Once the member has agreed to treatment, access to SUD treatment providers is well within the timely access standards set in contract. Once the member initiates treatment the behavioral health team will hand that member off to a peer support specialist to assist navigation through the engagement in treatment process all the way to completion.

Standard for timely appointment access for specialty behavioral health services, including SUD services:

> *For specialty behavioral health care for priority populations, the member is seen, treated, or referred within the following timeframes:*
>
> *a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135*
> *b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the intellectual/developmental disability (I/DD) population: Immediate assessment and entry. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist.*
> *c. IV drug users including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist.*
> *d. Opioid use disorder: Assessment and entry within 72 hours*
> *e. Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry*
> *f. Children with serious emotional disturbance as defined in 410-141-3500.*

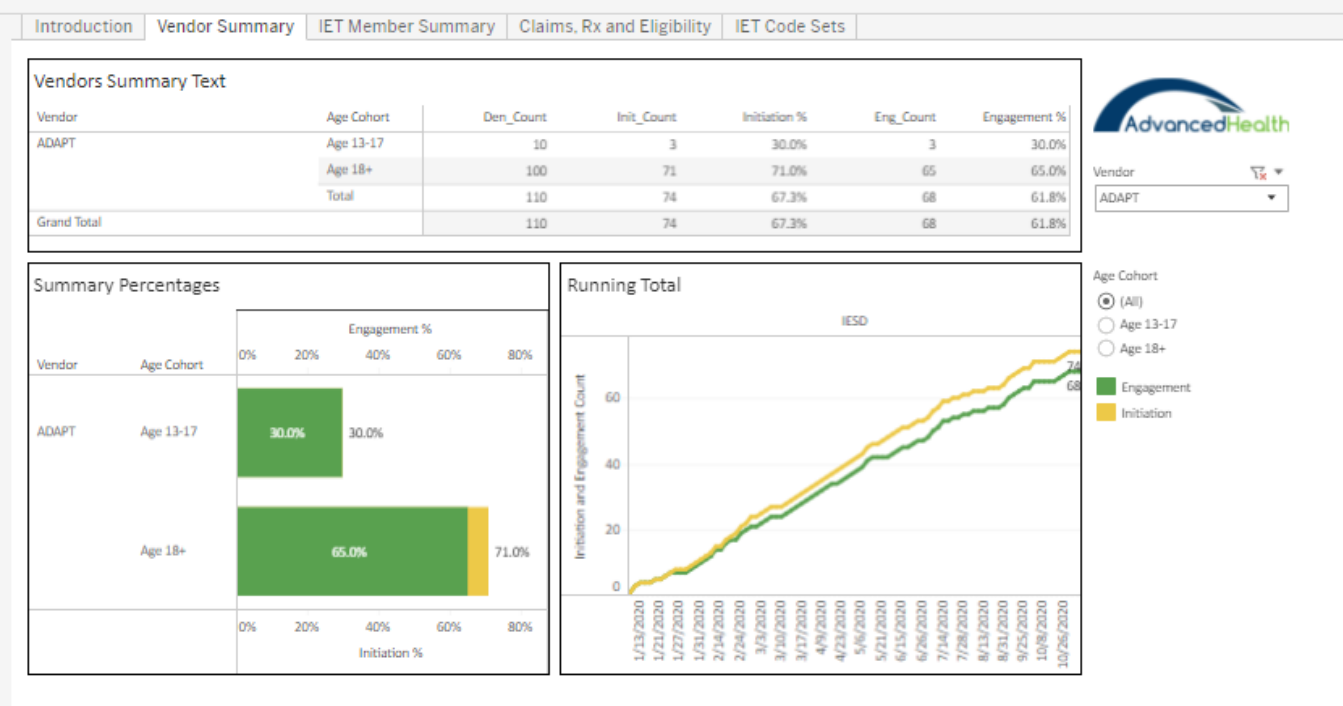
Better coordination and integration of referral pathways from PCP provider organizations to SUD treatment provider organizations would improve timely access to SUD treatment. Using established integrated behavioral health services to bridge the gap between diagnosis and initiation and engagement in treatment will improve member outcomes and support member engagement in their treatment plan through a more equitable, patient-centered care model.

## E. **Brief narrative description**:

Following the Quality Committee's discussion to refocus efforts on diagnoses in the primary care setting, the Advanced Health quality team went to work to determine the stakeholders at local clinics who would be willing to pilot this project and leverage existing Integrated Behavioral Health teams. The proposed intervention will use the Integrated Behavioral Health team to bridge the gap between positive SBIRT, AUDIT, or DAST screening and referral to treatment. The warm hand off model and traditional behavioral health techniques were suggested to usher members from diagnosis to successful initiation and engagement of SUD treatment. Determining the pilot clinic and initial meetings will take place in early 2022.

Advanced Health developed a dashboard for monitoring IET measure in 2020, however an internal claims processing system conversion in late 2021 prohibited the flow of data to this dashboard. In 2022 this dashboard will be updated

and will leverage internal data to monitor index episodes, episodes of initiation, engagement at the patient level, per vendor and per provider.




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

**Activity 1 description:** Identify pilot PCP clinic willing and able to participate in efforts to build collaborative networks with all treatment teams and organizations. Goals will be to

- evaluate those with positive SBIRT and/or DAST screenings for readiness to change through motivational interviewing by the Integrated Behavioral Health team,
- work with partners to streamline process of referral,
- develop a warm hand-off and build relationship that encourages the subsequent completion of SUD treatment.

☒ Short term or ☐ Long term

| **Monitoring measure 1.1** | Add text here | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No pilot clinic identified | Pilot clinic identified | 04/2022 | Begin meeting with all stakeholders | 06/2022 |

**Activity 2 description**: Develop workflow for Integrated Behavioral Health teams and Peer Support Specialists to assist member in initiation and engagement in treatment

☐ Short term or ☒ Long term

| **Monitoring measure 2.1** | Develop workflows in primary care and treatment setting |
|---|---|

| Baseline or current state | Target/future state | Target met by (MM/YYYY) | Benchmark/future state | Benchmark met by (MM/YYYY) |
|---|---|---|---|---|
| No workflows in place | Work flows in place | 8/2022 | Monitoring of workflows | 12/2023 |

**Activity 3 description**: Update data monitoring dashboard from CCO claims data that can be shared with community partners during the developmental, test, and implementation phases of the workplan

☐ Short term or ☒ Long term

| **Monitoring measure 3.1** | Update of claims-based data dashboard to be used for ongoing monitoring of the Initiation and Engagement for Alcohol or Substance Use Treatment performance rate. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Dashboard developed | Dashboard updated and distributed to clinics | 08/2022 | Continued monitoring and distribution of dashboard | 12/2023 |
| 37.8% Initiation rate<br>10.0% Engagement rate<br><br>Baseline is from CY 2020 final data reported in 06/2020 | 2021 improvement target:<br>Component 1, Initiation 30.3%%<br>Component 2, Engagement: 8.2%% | 12/2021<br>Report available 6/2022 | 2022 benchmark: component 1 Initiation: 42.0% component 2, engagement:13.9% | 12/2022 |
| Data not monitored monthly by Quality Committee | Review dashboard data at Quality Committee | 1/2022 | Monitor dashboard monthly at Quality Committee for testing period (6 months) | 7/2022 |

## A. **Project short title**: Improve Language Services Access

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

If continued, insert unique project ID from OHA: 45

## B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2020, Advanced Health's Board of Directors adopted the following definition of Health Equity, developed by the Health Equity Committee of OHA's Office of Equity and Inclusion, and adopted by the Oregon Health Policy Board and the OHA:

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

The board of directors adopted this definition to make clear Advanced Health's commitment to health equity and its intent to take action to promote health equity for Advanced Health Members and all community members in Coos and Curry Counties. The board of directors has charged Advanced Health to use this definition as a cornerstone for developing and operationalizing the organization-wide Health Equity Plan.

The adopted definition of Health Equity was distributed to committees and staff, including the Community Advisory Council (CAC) and the Health Equity Steering Committee. Both committees had in depth conversations about their interpretations of the definition and how the adoption of this definition by Advanced Health's board of directors would empower the work throughout Advanced Health staff and committees of advancing health equity. The Health Equity definition was shared on the internal electronic bulletin board for all staff to access and it has also been shared with staff during internal staff assessments. This definition has been presented to Advanced Health's other advisory committees to the board, the Clinical Advisory Panel and Interagency Quality Committee for review, discussion, and integration into their work.

Advanced Health adopted and uses the definition of cultural competence in OAR 943-090-0010:

> *"Cultural competence" means a life-long process of examining values and beliefs and developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient communication and interaction and preserves the dignity of individuals, families, and communities.*
>
> *(a) Cultural competence applies to all patients.*
>
> *(b) Culturally competent providers do not make assumptions on the basis of an individual's actual or perceived abilities, disabilities or traits whether inherent, genetic or developmental including: race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, gender transition status, level of formal education, physical or mental disability, medical condition or any consideration recognized under federal, state and local law.*

This definition paired with the CLAS Standards has guided Advanced Health's Provider Network Training Plan used to promote access and delivery of services in a culturally competent manner. Full details of the Provider Network Training Plan can be found in that section of this report, above.

In previous years, Advanced Health hosted and sponsored several trainings in the Coos and Curry communities related to health equity and culturally responsive services. Advanced Health brought in nationally recognized trainers to the area to provide staff, provider network and their staff, and community training on the Culture of Poverty, and sponsored local Poverty Simulations. Advanced Health sponsored training on Adverse Childhood Experiences (ACES) so that our region could "grow their own" ACES trainers and ensure the local availability of ongoing ACES trainings. See the South Coast Together project in this TQS report for more details on Advanced Health's ongoing work around ACE training and building resilience. Advanced Health brought in internationally recognized trainers to train on facilitating community conversations café style to promote and build Resilience. Advanced Health hosted trainings on Health Literacy and Culturally Linguistically Appropriate Services (CLAS) for network providers, their staff, Advanced Health staff, community partner's staff, and the Coos and Curry communities.

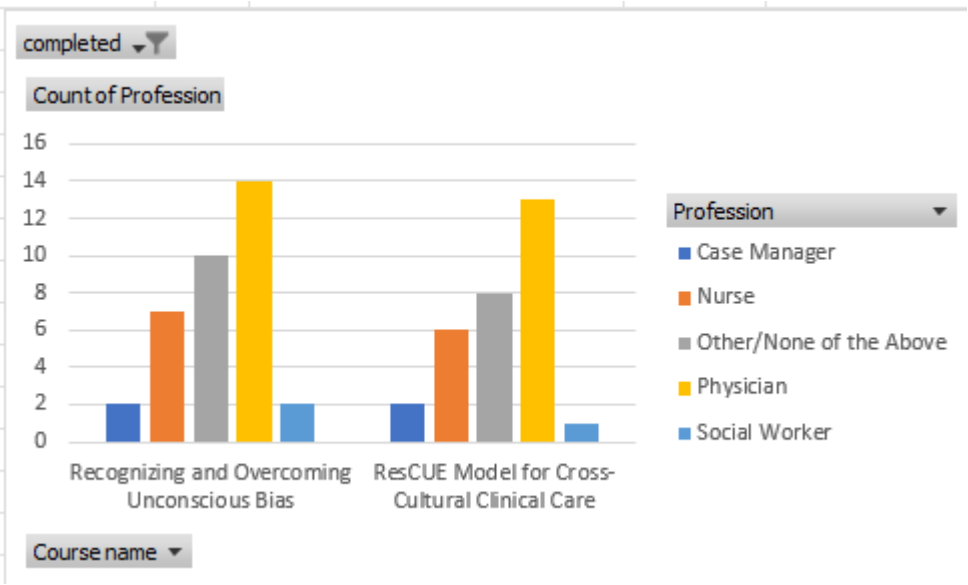
In 2019, Advanced Health contributed to the planning and was a fiscal sponsor to the 1st Annual South Coast Diversity Conference. We encouraged our staff, network providers, and Community Advisory Council (CAC) members to attend. Training topics included: Pronouns, Tribal History, Microaggressions in the Workplace, Behavioral Health, and a keynote from Alberto Mareno with an overview of equity programs and work done in Oregon.

In 2020, the South Coast Diversity Conference was planned for April and Advanced Health sponsored and planned to administer a livestream track that would be relayed to provider network clinics and hospitals as well as in conference rooms at Advanced Health and several community partners. Topics of training included: Unpacking Privilege, Implicit Bias, Supporting People with Differences, and Cultivating Empathy. Unfortunately, due to the COVID 19 emergency response in March and April of 2020 and large group restrictions, the conference was cancelled.

In 2020, Advanced Health offered an online, self-guided learning module: ResCUE Model for Cross-Cultural Clinical Care, to network providers and their staff. This training was chosen from OHA's menu of approved Cultural Competence & Continuing Education trainings, listed on the website of the OHA Office of Equity and Inclusion. The learning module was offered with continuing education credit attached, and thirteen users completed the training in 2020. Despite frequent communication and advertisements to network providers, clinical- and HR/business office staff of the training opportunity, local COVID-19 pandemic response efforts affected the bandwidth of the provider network during 2020, thus affecting the low turnout of training completion.

Advanced Health's 2021 provider network training plan was offered to all providers and their staff on an ongoing basis throughout the year. The format was two options to attend an online, self-guided training module: ResCUE Model for Cross-cultural Clinical Care and Recognizing and Overcoming Unconscious Bias. The trainings were offered at no charge to the attendee or healthcare facility, and continuing education credits were available.

**2021**




Advanced Health planned on restrictions being lifted and being able to plan and schedule in-person trainings. In-person trainings are a preferred method of training delivery to increase attendance rates and audience interest. Unfortunately, due to COVID in-person restrictions remained into 2021 and continued in 2022.

Advanced Health's primary and most complete source of data related to linguistic and cultural needs of members is the OHA 834 enrollment data. Advanced Health finds the REALD demographic data from OHA to be the most comprehensive data set available at this time. Using this REALD data, Analytics Department staff have developed a REALD demographic dashboard in Tableau to summarize the race, ethnicity, language, disabilities, and interpreter needs of Advanced Health members. The dashboard also includes a query feature to allow staff to find REALD data for a specific member. This function is used by the Grievance System Coordinator when reviewing grievance and appeal data to ensure we are offering materials in the member's language and to monitor for any trends related to equitable access to health care or the grievance system.

The Analytics and Quality department staff have worked together to develop a Language Access dashboard in Tableau. This dashboard is used internally by Quality department staff to monitor encounter data for members who have indicated they require interpreter services and follow up with the provider of services to determine whether interpreter services were offered, and if qualified or certified health care interpreter were made available to the member.

These Tableau dashboards are updated daily as enrollment and encounter data is updated.

2021 demographic data identifies the following enrollee characteristics:

| **Race and Ethnicity** | |
|---|---|
| American Indian or Alaska Native | 1.3% |
| Asian | 0.5% |
| Black or African American | 0.3% |
| Hispanic/Latino/Latina/Latinx | 2.9% |
| Native Hawaiian or Pacific Islander | 0.1% |
| White | 46.8% |
| Other | 0.5% |

| | |
|---|---|
| Declined to Answer | 9.3% |
| Did Not Answer/Unknown | 38.1% |

In 2017, Advanced Health added the Coquille Indian Tribal Clinic, now the Ko-Kwel Wellness Center, to our network. The Coquille Tribe has been an excellent community partner since the inception of the CCO, participating in our original Community Heath Assessment, sending a representative to our CAC, and participating in several community-wide events such as the South Coast Opioid Summit. Because of the wrap-around payments received by tribal clinics, most had no incentive to join CCOs, relying on the FFS benefit. However, this meant that many of their enrollees had difficulty accessing specialists. When they joined the CCO, the Tribal Clinic has been offered some special considerations: enrollees are only assigned to the clinic as their PCP if they request it or are established patients; the clinic has allowed their patients to choose whether or not to enroll in the CCO. Although the number of enrolled members remains small, we look forward to a long and productive partnership.

As Advanced Health works toward increasing the number of oral health providers in the contracted network, we look forward to adding oral health providers practicing at the newly expanded Ko-Kwel Wellness Center and the Dental Clinic owned and operated by the Confederated Tribes of the Coos, Lower Umpqua, and Siuslaw Indians.

**Language**

| | |
|---|---|
| Unknown | 1.3% |
| Chinese | 0.1% |
| English | 97.3% |
| Spanish | 1.2% |

*Note languages reported by fewer than 20 members are suppressed from this report

Within Advanced Health's PCP network, there are multiple bilingual providers: Spanish (6); Hindi (2); Taiwanese (2); Mandarin (1); Portuguese (1); and Nepali (1). Within the mental health and addiction treatment system, there providers who speak the following non-English languages: Spanish (5), Russian (3), Lakota (2), and Hindi (1). There is also a mental health provider who is fluent in American Sign Language. Within the oral health provider network, there are four providers who speak Spanish and one provider fluent in American Sign Language. One of the oral health providers who speaks Spanish and the provider fluent in ASL are both available to attend appointments in multiple Advantage Dental clinic locations within the Advanced Health service area.

Additionally, Advanced Health employs two Spanish language OHA qualified Health Care Interpreters. They both work in the Customer Service department and are available to assist any Spanish-speaking members who call or come to the CCO office. They are also available to attend appointments with members to offer high-quality, in-person interpretation services. This gives Advanced Health a ratio of 1 Qualified Spanish Health Care Interpreter to approximately 150 Spanish-speaking members. These staff are also able to lend their skills and knowledge to the process of developing and translating member materials and member health education information to ensure it is culturally and linguistically appropriate.

All enrollees with limited English proficiency are offered the option of being assigned to a provider who speaks their preferred language, if that language is represented among the panel of providers. In-person Spanish language interpretation is available from OHA certified and qualified health care interpreters. Advanced Health retains the services of two certified Spanish language health care interpreters, and contracts with the local Education Service District for additional interpreters and American Sign Language professionals. Telephone interpreter services are also available if

the patient's preferred language is not represented by a provider in Advanced Health's network or is not spoken by the member's preferred provider. Essential patient documents are available in Spanish or other languages upon request, and for those who are visually impaired, in large type and audio recording. More details are available in the Advanced Health *Language Access and Health Care Interpreter Services* policies and procedures.

Advanced Health also uses the annual Language Access Self-Assessment tool as a system-level method to evaluate the delivery system for linguistically appropriate services. The results of the self-assessment are monitored year to year by the quality department staff. The information is used to plan quality improvement interventions in collaboration with provider network and community partners to address areas of need identified in the assessment.

Advanced Health has always provided Language Line interpreter services to our membership and provider offices. We also provided healthcare interpreters. However, in 2018 we decided to develop a more formal Healthcare Interpreter Program, to include network provider training and education. This would ensure that our membership and provider network could access telephonic and in-person interpretation services, as well as understood the value interpreter services bring to quality healthcare. The CDC Plain Language Thesaurus is also provided to staff and providers.

In an effort to promote and provide education on the availability of language access services, outreach materials have been developed and are distributed via the Advanced Health website, mailed, or provided during network provider training sessions. Advanced Health has a provider-facing brochure that was developed in 2019 to educate the provider network about the availability and value of in-person, OHA-qualified Spanish language interpreter services from Advanced Health staff. Advanced Health includes healthcare interpreter services information in new provider orientations. In 2021, twenty-eight providers attended the new provider orientation sessions.

The Interagency Quality Committee took up the review and monitoring of the quarterly language interpreter services report in 2020. The Interagency Quality Committee includes representatives from organizations representing physical health, behavioral health, oral health, and non-emergency medical transportation services. This group reviewed data collection processes as well as clinic workflows and processes for identifying and offering services to patients with limited English proficiency. The committee identified gaps in how interpreter services are provided to members across the network. Every primary care organization follows Patient-Centered-Primary-Care Home standards regarding language access by providing access to language interpreter services unique to each organization. The Hospital provider and Substance Use provider also used language access lines as well as iPads with video translation. Many of the providers placed responsibility for requesting the language services on the Member. Although there were a few organizations which had bilingual providers that automatically scheduled Members identified with language needs with those providers, the majority of the providers had manual and ineffective methods of identifying Members with language access needs. It was not well-known within the community that Advanced Health had two OHA Qualified Medical Interpreters. Each organization relied on their language line or internally employed bilingual staff and providers to be available at the time of the service.

In addition to the assessment and direction from the Interagency Quality Committee, staff feedback from the organizational health equity self-assessment conducted in 2020 also indicated that while having two Qualified Health Care Interpreters on staff and available to provide in-person interpretation services for Members is a strength of the organization, access to and utilization of language interpretation services is still a concern.

During 2021 Advanced Health's on-staff Qualified Health Care Interpreters completed 23 interpreter assignments. Of those 23 events 16 were for medical services, 1 for dental services, 2 for behavioral health services, and 3 were classified as "other" which included South Coast Together Parent Café's, answering billing questions and interpreting online privacy policies and community event fliers.

Internal data dashboards, fueled by the 834 enrollment data files from OHA indicates that in 2021 Spanish remained the prominent non-English language spoken by our membership with 303 members identifying Spanish as their primary language. This is a 23-member increase from 2020. Internal dashboards are monitored frequently when considering member materials development and to identify potential health equity concerns.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

One of the ways Advanced Health is working to operationalize the health equity and cultural competence definitions is in the review and improvement of language services offered to and used by Advanced Health members with limited English proficiency. Improving the quality and utilization of language services will empower members with limited English proficiency to fully access the health care services available to them to improve and maintain their health.

In late 2019, Advanced Health participated in a pilot of the proposed Health Equity quality measure with OHA Analytics and the Office of Equity and Inclusion, along with a number of other CCOs. The purpose of the pilot was to test the specifications of the proposed language services access quality measure and assess CCOs' capability to report the data elements required for the measure and the quarterly reporting required in the 2020 contract. Advanced Health, like most other participating CCOs struggled to combine the disparate and fragmented data sources that were available and identified other gaps where data was not available at all. Ultimately, Advanced Health was unsatisfied with the report generated during the pilot and has determined that action is needed to improve both access to and utilization of interpreter services as well as data collection and reporting capabilities.

In 2020, Advanced Health planned to form a cross-functional Language Services Action Team, including staff from quality improvement, compliance, member services, analytics, certified health care interpreters, and executive leadership to develop and guide an improvement work plan. The group met in February 2020 for a kickoff meeting to review the results of Advanced Health's 2020 Language Services Self-Assessment and the results of the 2019 language access services quality measure pilot. With the onset of the COVID-19 pandemic and the resulting public health emergency response, staff time and resources were redirected. Resources focused on maintaining core operations and services as staff quickly shifted to working remotely. Customer service staff and the qualified health care interpreters shifted their priorities to assisting with the pandemic response by providing information to members and the community about the rapidly changing situation, including how to access health care services for routine, urgent, and emergency care as well as COVID-19 testing and safety precautions. The qualified health care interpreters on Advanced Health's staff were key members of the local pandemic response, staffing the Spanish language COVID-19 information line and offering interpretation services for telehealth visits. The Language Services Action Team did not meet again in 2020 in its original form.

The Interagency Quality Committee took up the review and monitoring of the quarterly language interpreter services report in 2020. The Interagency Quality Committee includes representatives from organizations representing physical health, behavioral health, substance use treatment, oral health, and non-emergency medical transportation services. This group reviewed data collection processes as well as clinic workflows and processes for identifying and offering services to patients with limited English proficiency. Advanced Health quality and analytics staff worked to implement several recommendations to improve data collection, reporting, and patient identification. A Tableau dashboard was implemented in 2020, using flags in the enrollment 834 files, to improve identification of members requiring interpreter services. The dashboard is used by Advanced Health quality staff to give feedback and reports to provider organizations on the need for interpreter services and where members with limited English proficiency are accessing health care services.

In 2020, as part of the process of routine provider network auditing, Advanced Health added elements to its survey and attestation tools to assess compliance with CLAS standards. The following elements were added to assess provider network implementation of CLAS standards 5-8:

- Patient forms are available for persons with limited English proficiency and in preferred alternate formats. (Example: sixth grade reading level, large print, preferred reading language or available staff to assist with completing forms).
- Patients are informed of available language assistance services in their preferred language, verbally and in writing, and are provided at no cost.
- Certified language interpreters are used.

Preliminary results of the survey, as well as data available from the 2020 quarterly language access reports indicates that not all providers are using OHA qualified or certified health care interpreters. Advanced Health will focus on improving access to health care services for members with limited English proficiency by increasing availability of high-quality in-person certified health care interpreter services.

Advanced Health provides a language line service to members and the provider network. This language line service was reviewed by IT staff to ensure the offered services are being fully utilized and that appropriate staff are trained on how to use the telephonic and video services. To be HIPAA compliant, Language Line doesn't collect any identifiable information during the calls, so we get very little data collection when using the Language Line services. This is understandable, but it presents difficulty when trying to use the data to monitor for adequate member access to interpreter services.

Throughout 2021, our website was updated with Language sections for both members and providers. The member-facing section informs members of the language access services available to them at no cost, how to access those services, and of best practices for high quality language services, including use of qualified or certified interpreters. Advanced Health translated additional member-facing materials into Spanish and offers Large Print whenever possible. Eight documents were included in these additional formats during the year with plans to review annually and make necessary changes. The provider web page includes information about regulatory and contractual compliance related to language services, as well as Advanced Health's policies and procedures for language access and interpreter services, and best practices to ensure high quality services are delivered to patients with limited English proficiency.

A key goal from Advanced Health's Health Equity plan is to increase access to health care interpreters by increasing the number of OHA qualified and certified interpreters available locally for in-person, telephonic, and virtual language assistance. This goal is informed by recommendations from staff, the Interagency Quality Committee, and the Clinical Advisory Panel. It is also aligned with CLAS Enhanced National Standard number seven, "Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided." When training opportunities are identified, Advanced Health will offer scholarships to local individuals interested in becoming an OHA qualified or certified health care interpreter and offering services to Advanced Health members and the community. In 2021, Advanced Health staff also explored the feasibility of developing a local health care interpreter training program in partnership with local community-based organizations, local workforce development initiatives, and under the guidance of OHA. After some initial inquiries and discussion of the program requirements with Advanced Health staff and the Interagency Quality Committee, the decision was made in mid-2021 not to pursue development of a local in-person training program. With the impacts of the pandemic response still present in the community, it did not appear that a local organization had the capacity to take on the project. We also discovered many more options are now available for virtual trainings.

## E. **Brief narrative description**:

Advanced Health's quality staff will continue to work with the Interagency Quality Committee and the analytics team to improve data collection and reporting processes for the quarterly language interpreter services reports. The results of the quarterly reports will be monitored by the Quality Committee and will be presented to the Community Advisory Councils.

Plans to expand our Health Care Interpreter Program to encompass facilitation of all languages via video translation with Language Line will be developed in early 2022. Although Language Line has been a service we have provided for some time, this new program should enhance its utilization since Advanced Health will be able to inform members and providers of the service and facilitate if themselves. We will have our staff interpreters facilitate the video interpretation with Advanced Health devices, as they understand the importance of professional interpretation, even if it is for a language they cannot speak or understand. Activities involve training of staff, development and distribution of informational materials, and monitoring utilization.

As discussed in the section above, Advanced Health decided against developing a local interpreter training program. Instead, the Interagency Quality Committee and our internal Health Equity Steering Committee worked to develop a scholarship program, funded by a health equity budget line, for local healthcare interpreters to become certified. This program offers a full scholarship for current bilingual allied health staff to become certified using any one of the OHA approved courses. This scholarship opportunity was communicated via the Interagency Quality Committee in November of 2021 followed by dissemination of an electronic application process and resources on the OHA approved certification courses. Understanding the continued bandwidth issues faced by our community provider partners this scholarship will remain open until the allocated funding is exhausted, which is anticipated to be the majority of 2022.

An Advanced Health Certified Health Care Interpreter was asked to participate and provide interpretation services in a partner organization's Family Café's being held for the Spanish speaking community. The topics of the events were related to education, Covid-19 response, and access to healthcare. From this experience, Advanced Health has adopted a new activity for 2022. We will hold Listening Sessions with various cultural organizations in our community to better understand their challenges and needs in accessing care and approaches to serving members in a manner more compatible with their cultural health beliefs, practices, preferred language, and communication needs.

Improving access to and utilization of language interpretation services for members with LEP will improve members' experience in accessing care and empower them to fully participate in their care.

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

**Activity 1 description**: Develop scholarship program for Health Care Interpreter Certification and award funds.

☒ Short term or ☐ Long term

| **Monitoring measure 1.1** | Development of Healthcare Interpreter Certification scholarship | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Scholarship program developed and communicated to local community provider partner clinics | 3 participants awarded scholarships for certification | 8/2022 | 5 participants awarded scholarships for certification | 12/2023 |

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

☒ Short term or ☐ Long term

| **Monitoring measure 2.1** | **Hold Listening Sessions** | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No listening sessions | Reach out to Coos Hispanic Leadership, local Native American tribes, Star of Hope and Community Living Case Management to schedule listening sessions | 09/2022 | Work collaboratively with community partners to better understand barriers to care and develop approaches to serving members in a way that better supports their cultural health beliefs, practices, preferred languages, and communication needs. | 06/2023 |

**Activity 3 description**: Expand Advanced Health's Health Care Interpretation services to include in-person facilitation of Video Interpretation at member or provider's request at any health care facility in our service region.

☒ Short term or ☐ Long term

| **Monitoring measure 3.1** | Initiate Expanded Program | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| In-person Health Care Interpretation available in Spanish only. | In-person facilitation of Video Interpreting available for all languages. | 04/2022 | Monitor utilization of services | 04/2023 |
| **Monitoring measure 3.2** | Develop and distribute materials for expanded program | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| I Speak cards available; Health Care Interpreter Services flyer is developed for Spanish language interpretation. | Develop or edit existing materials to inform members and providers of expanded service. | 04/2022 | All members who have a Primary language as non-English with receive information about the program in their language, and an I Speak card. Providers will receive updated information. | 05/2022 |
| **Monitoring measure 3.3** | Monitor progress toward meeting improving utilization of high-quality language access services and toward meeting the requirements of the CCO quality incentive measure. | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 24.9% of LEP Members receiving interpreter services | 27.4% | 12/2021 (Aggregate 2021 Q1-Q4 data from | *30.1% *Target will be adjusted when 2021 final rate is | 12/2022 |

| | | | | |
|---|---|---|---|---|
| at health care encounters. (Aggregate 2020 Q1-Q4 data from quarterly interpreter services reports. Report available by 3/31/2021.) | (10% improvement from 2020 baseline) | quarterly interpreter services reports. Report available by 3/2022) | calculated. Target will be set at 10% improvement from 2021 rate. | |

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

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

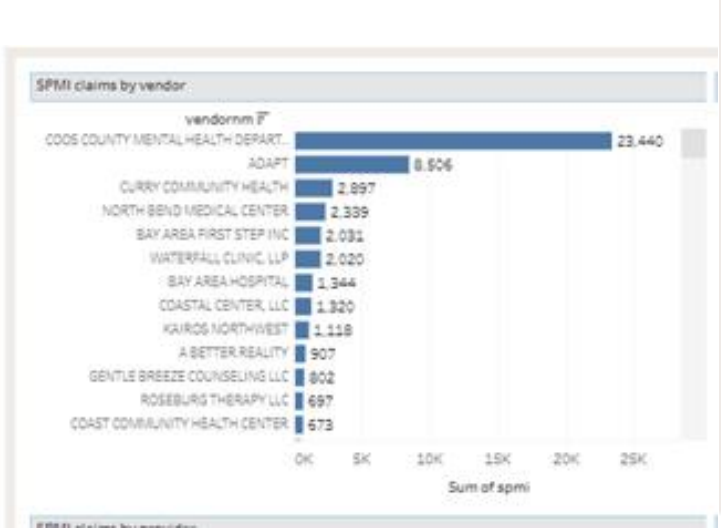
If continued, insert unique project ID from OHA: 46

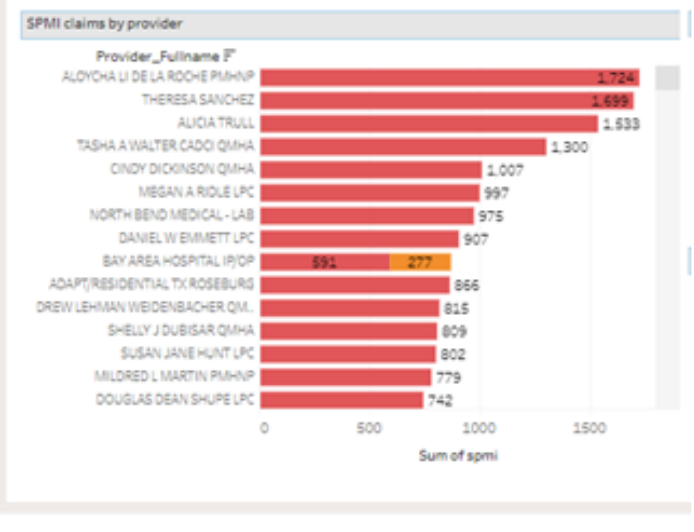
## B. **Components addressed**

i. Component 1: Serious and persistent mental illness
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

## C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

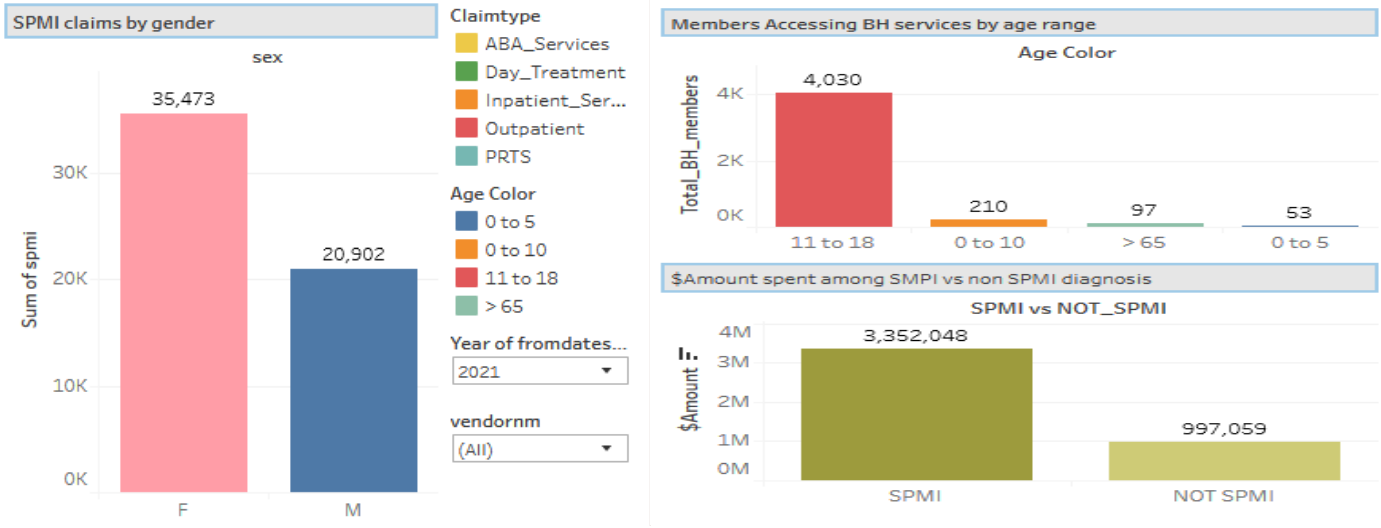
Advanced Health can access claims data to identify Serious and Persistent Mental Illness (SPMI) diagnoses coming through claims and pair the data with services being accessed. Through this reporting, a global picture is created depicting access to behavioral health services for members with SPMI. Claims can be filtered by types of services accessed including care coordination, therapy, and medication management to ensure equitable access for Advanced Health Members with an SPMI diagnosis.



Health Risk Assessment Screening tools were also used as a secondary method to identify SPMI needs through self-reporting. Health Risk Assessment (HRA) screenings are delivered to the member upon initial enrollment with the plan and annually thereafter. Members who do not respond to the mailed surveys are contacted by phone by customer service to ensure that all members needing additional services are identified. Members are also referred for additional services, including Intensive Care Coordination, through primary care providers, case managers, community or social service organizations, or by self referral or referral by a guardian or care-giver.

The stratification of members with an identified SPMI diagnosis in 2021 is listed below. Advanced Health will continue to track these data points to determine network adequacy and to ensure that members are receiving the appropriate care. The dashboard also allows Advanced Health to identify issues of health equity, ensuring all members have equal access to care.




The dashboard view shown below allows Advanced Health to identify specific members with an SPMI diagnosis and determine what services they are accessing to evaluate the need for additional services including ACT, EASA, or IIBHT. Individual cases are staffed by the ICC director with the ICC teams to evaluate high-needs members for care coordination and possible linkages to other special services with the goal of preventing crisis and relapse by providing a robust, member-centered treatment plan and working with the member to meet their health care goals.

BH member's overvier

| membid | Member_name | proccode | Qty of Service | Provider_Fullname | Vendor name | SP |
|---|---|---|---|---|---|---|
| [redacted] | [redacted] | 90832 | 1 | GEORGIA ENGLAND QMHP-C | CURRY COMMUNITY HEALTH | sp |
| | | 90834 | 1 | GEORGIA ENGLAND QMHP-C | CURRY COMMUNITY HEALTH | sp |
| | | | | KEQING SUN QMHP | CURRY COMMUNITY HEALTH | sp |
| | | 90837 | 1 | ERIN KATHLEEN PORTER QMHP MSW | CURRY COMMUNITY HEALTH | sp |
| | | H0032 | 1 | ERIN KATHLEEN PORTER QMHP MSW | CURRY COMMUNITY HEALTH | sp |
| | | Q3014 | 1 | GEORGIA ENGLAND QMHP-C | CURRY COMMUNITY HEALTH | sp |
| | | T1016 | 1 | GINA M MCDONALD TWH-CHW | CURRY COMMUNITY HEALTH | sp |
| | | | 2 | GINA M MCDONALD TWH-CHW | CURRY COMMUNITY HEALTH | sp |
| | | | 3 | ERIN KATHLEEN PORTER QMHP MSW | CURRY COMMUNITY HEALTH | sp |
| | | | | GINA M MCDONALD TWH-CHW | CURRY COMMUNITY HEALTH | sp |
| | | | 4 | ERIN KATHLEEN PORTER QMHP MSW | CURRY COMMUNITY HEALTH | sp |
| [redacted] | [redacted] | 96127 | 1 | CAROL SUE FRANK MD | BAY CLINIC LLP | sp |
| | | 99214 | 1 | CAROL SUE FRANK MD | BAY CLINIC LLP | sp |
| | | G8431 | 1 | CAROL SUE FRANK MD | BAY CLINIC LLP | sp |

The behavioral health team at Advanced Health also participates in several community collaboration meetings monthly, including the mental health/law enforcement meeting which collaborates with local law enforcement and community representatives such as the homeless resource center, the County Mental Health Provider (CMHP), and the hospital psychiatric liaison. The CMHP hosts a monthly meeting of agencies that are involved in direct patient care as well as supported employment and peer support services representatives to share new initiatives and engage in meaningful dialog aimed at cross collaboration between agencies.

Behavioral services have been integrated in all school districts in Coos and Curry County. Advanced Health has also partnered with the FQHC's to include school-based clinics to allow for medical appointments in addition to school-based therapists. To increase the exchanged of information and allow for the coordination of services, Advanced Health has put forth funds to allow greater access to a new EHR, Epic, that will be used in the largest hospital, Bay Area Hospital, and the two largest clinics, North Bend Medical Center and Bay Clinic. The conversion to Epic went into effect in mid-2021. Coos Health and Wellness and Coast Community Health Center also plan to transition to Epic in 2022. In addition to the community wide adoption of Epic, community and provider partners are also able to coordinate care plans through Activate Care. Activate Care is the software platform Advanced Health has purchased to facilitate care coordination information and care plans and ensured timeframes are met by care coordinators. Activate Care also allows those care plans and coordination information to be shared with the Member directly as well as other members of the care team outside of Advanced Health.

Advanced Health's geographical area of Coos and Curry counties made significant gains in terms of access to and availability of providers over the course of the previous year. Overall, our contracts with provider rose to a total of 240 Behavioral Health and SUD providers from the previous year's 172 providers. Advanced Health continues to accept applications to enter the network from providers meeting credentialing criteria.

Integrated behavioral health has been contracted in four primary care clinics, serving approximately 80% of Advanced Health members, allowing members and PCPs quick access to mental health consults. Integrated behavioral specialists are trained in referrals to specialty programs once a member has been identified as needing additional behavioral health or substance abuse services.

Advanced Health is currently serving approximately 26,000 Medicaid Members. Six months after the federal state of emergency pandemic response ends, we expect to see a significant decrease in membership once the redetermination process is implemented by OHA. The decline in membership is expected be gradual over the course of about 12 months, after which membership levels are expected to remain some 2% to 3% higher than pre-pandemic levels. We assume we will be serving more clients with mental health needs as the stresses and social isolation of the pandemic response continues to deteriorate the health and wellbeing of our population. The toll this pandemic has taken on the mental health of our communities will be felt for years to come, and we must be prepared to assist with the healing.

Advanced Health welcomed two new staff members to the behavioral health team as director and manager. They embarked on a listening tour throughout the service area to engage with providers, community-based organizations, and social service agency partners in the community. The goal was to learn from them what they needed for support, how their organizations functioned and partnered with other programs, what they felt their strengths were and how they benefitted our communities, barriers that needed to be addressed, and success stories. These listening sessions proved invaluable for all involved. Great relationships are being built and all are focused on bettering our delivery of care to our members.

Our region welcomed a pediatric psychiatrist, Dr. Rainie Davies to our provider network. She is involved with a new program called Starfish, sponsored by Waterfall Community Health Clinic with the help of Advanced Health, that serves

both children with mental health diagnoses as well as those with autism. The program launched in April 2021, and in its first year Starfish has served just shy of 200 individual patients; 45 of whom have autism. The number of autistic youths served is expected to double in the coming year. Waterfall was also able to provide Applied Behavioral Analysis services to 833 members in its first year.

While meeting with our integrated behavioral health teams in the surrounding clinics we heard just how important this role has been in both strengthening the alliance of the physical wellbeing with mental health. Our local primary care providers lean heavily on our behavioral health teams to meet the needs of our members swiftly, seamlessly, and effectively. The partnership is fantastic and valued by the professional team as well as our members who have a warm hand-off and care within the same visit.

Our local CMHP, Coos Health and Wellness, has successfully launched an In-home Intensive Behavioral Health Therapy program in April 2021. This is something our local area has much reason to be proud of. We have successfully served 7 youth in 2021 with this incredibly supportive program. 4 of the 7 “graduated” from the program, one remain involved with the team and two discharged against medical advice. All are considered successful as education, support, and therapy were provided; seeds were planted for growth and connections were made for future needs as they arise.

The Epic EHR transition was successfully rolled out in 2021 in our largest regional hospital, Bay Area Hospital, as well as with our two largest area clinics. This EHR platform will improve patient and member treatment and ultimately outcomes as information and plans of care are easily shared among providers. Work is continuing to be done to allow all organizations, no matter their health record platform, access to EPIC.

The ACT team at Coos Health and Wellness has increased their capacity over the past several years as well. They had 21 members served in 2020 and that rose to 35 members served by the end of 2021. Our internal Advanced Health ICC program that focuses on serving members with special health care needs saw an increase in members during 2021 as well, serving approximately 350 unique members throughout the course of the year.

Advanced Health continues efforts to improve care and help coordinate services. A few community-wide meetings we participated in in 2021 included: South Coast Equity Coalition, community partner-based meetings with Bay Area Hospital daily when a youth is being held in the ED, Community Connections, Mental Health and Law Enforcement collaborative monthly meetings, Community Advisory Council (CAC) for both Coos and Curry Counties, as well as the four levels of Systems of Care meetings.

ADAPT took on the contract as the County Mental Health Program in Curry County in mid-2021. The contract was previously held by Curry Community Health for a number of years. Advanced Health coordinated closely with Curry Community Health, ADAPT, and the Curry County board of commissioners to support the successful transition. ADAPT has proved to be an incredibly nimble, capable, and responsive organization as it assumed the role of providing crisis mental health services in Curry County. Our partnership is off to a great start, and we are looking forward to its growth in the region in 2022.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Prior to 2020, Advanced Health CCO partnered with the local County Mental Health Program (CMHP) for primary management and service delivery of all mental health related services. Members were required to be an “open client” with the CMHP with a full behavioral health assessment and treatment plan prior to being eligible for mental health services. Advanced Health underwent a major transformation in Behavioral Health services in 2020, which paved the way for services to be contracted with multiple providers rather than delegating all services to the County Mental Health Provider (CMHP). Advanced Health continues to contract with the local CMHPs while expanding network providers to include individual behavioral health providers and integrated behavioral health providers co-located in primary care and

specialty clinics. This shift provided expanded and increased access to Behavioral Health services for all members, and particularly for those with serious and persistent mental illness (SPMI).

The service expansion created foundational changes to services to include:

- New contracts with local mental health providers allowing a broader network for Members to choose from.
- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

With multiple new providers, the need for new accountability to identify the SPMI population arose. Creating a new system with the capabilities to identify the needs was the first task in the 2020 TQS project. The roadmap to improving behavioral health access and integration begins with creating a data-driven approach to identify the high risk and vulnerable population of members with SPMI and then to extend that data to the behavioral health provider network.

Advanced Health's Behavioral Health Director began by putting in place guidelines to ensure members with SPMI are not only connected with an appropriate Integrated Behavioral Health care team but also enrolled in Intensive Care Coordination Services (ICC), or Assertive Community Treatment (ACT), when needed, and offered Skills Coaching and Supported Employment. These care standards when utilized together provide a comprehensive treatment model to support members with SPMI in an member-centered, empowering recovery-based model.

The guidelines for the expansion of services are focusing on addressing the following needs:

- SPMI: Early intervention involves connecting SPMI members with the appropriate levels of supportive services and decreases the need for higher levels of care. Ongoing monitoring and identification for this vulnerable group will be key in improving outcomes.
- Cultural Considerations: Interventions must be targeted and culturally appropriate to be useful to members literacy and language needs.
- Access: Quality and adequacy of services
- Health equity: Implementation of identification and tracking mechanisms to better serve the SPMI population through identification, referral, and ongoing tracking.

Advanced Health continues to define the context of this project as it is written above. We are thoroughly committed to monitoring the needs of the SPMI member population while focusing heavily on cultural considerations, access, and health equity strategies.

E. **Brief narrative description**:

The next steps in the TQS project include collaborating with providers to offer access and education for a provider facing dashboard that will allow for ongoing initiatives aimed at identifying gaps in services and seeking provider feedback on areas for growth opportunity in serving our most vulnerable populations. Because of the complicating factors related to Covid-19, Advanced Health elected to postpone the provider rollout to allow providers to focus on shifting their practices to telemedicine in 2020, and postponed again in 2021 due to workforce shortages and limited organizational capacity created by the ongoing pandemic response.

Ongoing areas of improvement include collaboration with providers which will begin in the next few months. We look forward to working with the community of providers in this effort. Advanced Health is also working on identifying more

areas of potential health inequities in the dashboard with the goal of breaking down services accessed by race and language.

Advanced Health continues to accept applications to enter the network from providers who meet credentialing standards.

Listening sessions held in 2021 proved invaluable in helping form this 2022 iteration of the roadmap we are using to increase members' access to care, experience of care, and positive outcomes while increasing provider satisfaction by removing barriers and increasing communication.

One area of improvement we believe will bring a great deal of satisfaction to our community and our provider network is focused on our provider portal. Advanced Health is aware that to serve our community better, we must make finding the right help by the right provider easy to navigate. Being able to quickly and easily search for providers that meet the needs of our members, whether it be for specific services such as EMDR or specific language for ease of communication, is key to our members' and providers' experience and ability to follow through to receiving the help they need. It was mentioned multiple times during our listening sessions that it was too difficult to wade through the list of providers to find one that was accepting new patients, let along one who specialized in youth for instance.

It was also clear that those providing services felt siloed and unaware of the services that existed in our local area nor how to access them if they were aware. Future goals include developing a platform or community meeting to bring all behavioral health services and providers together to share information, discuss and break down barriers.

In 2021, Advanced Health in collaboration with Southwestern Oregon Independent Practice Association (SWOIPA) developed a new Provider Recruitment program. Advanced Health and SWOIPA each allocated funds to the program for the purpose of increasing network capacity in areas of identified need such as psychiatry, urology, etc., in alignment with community need and Advanced Health's delivery system network plan. The program is intended to increase access to care for all community members and support the community entities in recruiting and retaining providers.

Advanced Health will continue to support workforce recruitment and retention for BH staff in our community via the provider recruitment program which offers up grant funding for local contracted providers to recruit new providers and retain current providers. Not only will we continue to support recruitment financially, but by increasing our collaboration, communication and overall support of our existing services, then providers will likely experience a higher satisfaction in their practices thus improving provider retention rates as well.

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

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

☐ Short term or ☒ Long term

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

| | | | | |
|---|---|---|---|---|
| | (5% increase from 2021) | | (10% increase from 2022) | |

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

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement**:

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

**Activity 3 description**: Rollout Tableau dashboards to community providers.

☒ Short term or ☐ Long term

**Monitoring activity 3 for improvement**:

| **Monitoring measure 3.1** | Train and implement Tableau Dashboard for community providers. Monitor percentage of providers actively using software and number of Members actively enrolled in behavioral health services. Due to Covid restrictions and pandemic-related strains on the local health care system, these targets and benchmarks are still in the development phase. Advanced Health will continue to engage with providers to educate on access and provide community-based solutions. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| No documented procedure | Develop written procedure to monitor dashboards and reach out to providers | 05/2022 | Roll out dashboards and procedure to community providers | 08/2022 |
| No improvement targets set | 15% of providers actively engaging with data | 06/2022 | 25% of providers actively engaging with data dashboard | 12/2022 |

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

☐ Short term or ☒ Long term

**Monitoring activity 4 for improvement**:

| **Monitoring measure 3.1** | Increase in ACT services | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 34 clients served (CY 2021) | 50 clients served | 12/2022 | Maintain capacity to serve 50 clients per year | 12/2023 |

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

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

If continued, insert unique project ID from OHA: 361

B. **Components addressed**

i. Component 1: PCPCH: Member enrollment
ii. Component 2 (if applicable): PCPCH: Tier advancement
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☒ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2017, the Patient-Centered Primary Care Home (PCPCH) standards were revised and moved from a 3 tier recognition system to a 5 tier recognition system. OHA monitors CCO Member enrollment with a PCPCH through the Patient-Centered Primary Care Home (PCPCH) Enrollment quality measure which uses a weighted formula to give a higher rating when more members are empaneled with higher-tier PCPCH recognized clinics. The PCPCH measure was part of the CCO incentive measure set through 2019. In measurement year 2020, the measure was no longer incentivized through the CCO quality program. However, beginning in the 2020 CCO contract there are provisions requiring CCOs to financially support PCPCH recognized practices in their network.

In 2018 Advanced Health achieved a 68.8% rate for the PCPCH Enrollment measure, surpassing the OHA benchmark for that year.

In 2019 Advanced Health's rating improved to 76.8% with the addition of a newly recognized tier 4 clinic and another clinic moving from tier 4 to 5 star.

In 2020 Advanced Health's weighted PCPCH rate improved again to 86.2%. Advanced Health was the top performer among all Oregon CCOs for this measure in 2020 with 93% of members enrolled with a PCPCH clinic and 56% of members enrolled with a 5 Star clinic. At the end of 2020 the two largest primary care clinics in Advanced Health's

network were both 5 Star PCPCH recognized clinics. More detail on Advanced Health's year-end 2020 PCPCH member assignment at all tier levels is given below.

| PCPCH Recognition Level | Number of Members Assigned | % of Total Advanced Health Members |
|---|---|---|
| 5 Star | 13,234 | 56% |
| Tier 4 | 5,171 | 22% |
| Tier 3 | 2,657 | 11% |
| Tier 2 | 773 | 3% |
| Tier 1 | 0 | 0% |
| Not recognized | 1,965 | 8% |

In 2021, nine clinic sites in the Advanced Health provider network were due for PCPCH re-attestation, but only eight of them re-attested. One was unable to re-attest at their scheduled interval due to lack of staff capacity to manage the process. This clinic site also added primary care capacity in 2021 and had been accepting a larger share of Advanced Health members as a result. For these reasons, the loss of this clinic's PCPCH recognition status had a larger than expected impact on the overall percentage of members empaneled with a PCPCH-recognized clinic. Eight clinics re-attested in 2021, however none of them moved up in tier level. Pandemic response efforts and staffing shortages took a toll on the administrative capacity of provider organizations everywhere.

OHA's final calculation of CCO performance rates are not yet available for 2021. Advanced Health's rate will decline from 2020 performance for the reasons discussed above, however overall performance is still expected to be strong compared to the statewide rate as the majority of Advanced Health members are still enrolled with a 5 Star PCPCH clinic. The details on Advanced Health's year-end 2021 PCPCH member assignment at all tier levels is given below.

| PCPCH Recognition Level | Number of Members Assigned | % of Total Advanced Health Members |
|---|---|---|
| 5 Star | 13,775 | 56% |
| Tier 4 | 5,175 | 21% |
| Tier 3 | 2,453 | 10% |
| Tier 2 | 0 | 0% |
| Tier 1 | 0 | 0% |
| Not recognized | 2,985 | 12% |

## D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

One focus area of the 2015-2018 Coos County Community Health Improvement Plan was to increase access to care providers. This priority was identified from the Coos County Community Health Assessment, reviewed and approved by the Coos County Community Advisory Council. The subcommittee/workgroup tasked with increasing access to care chose as one of their strategies to form a PCPCH learning collaborative to support local clinics and providers in attaining PCPCH recognition and reaching their target recognition levels. This strategy also aligns with OHA's PCPCH Enrollment quality performance metric for CCOs, the PCPCH area of focus in the Transformation Plan, and with several requirements for clinics participating in the CPC+ program.

Advanced Health had conducted a performance improvement project around PCPCH enrollment in 2014 and 2015 with a core strategy of providing technical assistance to clinics to attain PCPCH recognition. By 2016, 88.6% of Advanced Health members were receiving primary care services at a Tier 3 PCPCH recognized clinic.

In 2017 the recognition standards for PCPCH were revised and the tier structure was expanded from three levels to five. The change to the tier structure precipitated a change to the OHA PCPCH Enrollment measure calculation. With the threshold for the PCPCH measure remaining at 60% and the new calculation methodology, it became impossible for a CCO to meet the measure if the clinics in their provider network remained at Tier 3.

In 2017 the Access to Care Community Health Improvement Plan Subcommittee formed the PCPCH Learning Collaborative and worked to engage representatives from interested clinics in both Coos and Curry counties, including Bay Clinic, North Bend Medical Center, Waterfall Community Health Center, Coast Community Health Center, Curry Community Health, and Curry Health Network. At the beginning of 2017, all these clinics were recognized as Tier 3 PCPCH clinics. The PCPCH Learning Collaborative, led by Advanced Health's Quality Improvement Specialist and the Community Engagement Team, developed and shared tools to assist fellow collaborative members to achieve higher levels of PCPCH recognition.

By the end of 2017, Bay Clinic, North Bend Medical Center's Coos Bay clinic, Coast Community Health Center, Curry Health Network, and Curry Medical Center of Curry Health Network had all attained Tier 4 PCPCH recognition. The North Bend Medical Center offices in Myrtle Point, Coquille, Bandon, and Gold Beach, and Waterfall Community Health Center had all maintained Tier 3 PCPCH recognition.

In 2018, the PCPCH Learning Collaborative met quarterly and included discussion topics such as, supply and demand, empanelment, and care team models. Some clinics planning to attest to a higher tier in early 2019 held focused work sessions with the Advanced Health Quality Improvement Specialist to review relevant standards, processes, and documentation requirements. Also in 2018, Advanced Health added another Tier 4 PCPCH recognized clinic to the contracted provider network in Curry County, expanding access for Advanced Health members living in the area.

For the 2019 measurement year, the OHA Metrics and Scoring Committee raised the threshold for the PCPCH quality incentive measure to 68.0%. Advanced Health's 2019 final PCPCH quality measure rate was 76.8%. While this is above the threshold set for 2019 performance, Advanced Health remained committed to improving the members' experience of care through ensuring timely access to culturally appropriate and responsive care, and the PCPCH model is one vehicle to promote these values. PCPCH clinics in Coos and Curry County are working to offer more integrated services, including behavioral health and oral health. Clinics are focusing on enhancing processes for patient outreach and engagement. Bay Clinic became a 5-Star PCPCH site in 2019.

Despite the barriers of COVID-19, North Bend Medical Center's Coos Bay location became a 5-Star PCPCH site in 2020. And through the continued COVID-19 pandemic response in 2021, North Bend Medical Center's Coos Bay location re-attested to 5-star recognition in 2021 and is pending a site visit in 2022 to confirm their recognition status. They also continue to grow satellite clinics to obtain higher tiers through the addition of services.

2021 presented multiple challenges for our local community clinics and Advanced Health in the area of data collection. The community wide Electronic Health Record conversion to Epic made data collection for year end reporting as well as monthly progress updates challenging as Advanced Health's third-party vendor [MedInsight] fought to obtain and consume the new formatted data. Internally at Advanced Health we had our own claims processing system conversion in Q4 of 2021 as well as staff shortages in our analytics team which made internal dashboards used to generate gap lists and other clinic progress reports difficult.

### E. **Brief narrative description**:

Advanced Health is currently contracted with all primary care providers in Coos and Curry county, so contracting with providers not currently in the network is not a viable strategy to increase PCPCH enrollment. Instead, Advanced Health will continue to keep in close communication with all primary care organizations in the network regarding their plans for PCPCH recognition tier advancement and will provide targeted technical assistance as needed to support provider

organizations in meeting those goals. Both Advanced Health's Quality Manager and Quality Improvement Specialist have experience with PCPCH standard implementation and routinely check in with the quality staff at PCPCH recognized clinics.

In 2020 Advanced Health developed PMPM payment mechanisms in contracts with PCPCH recognized clinics. The payments increase with the number of members assigned to the clinic for primary care, offer higher payments for higher tier recognition, and increase year-over-year. These PMPM payments meet the CCO contractual requirements and also provide a financial incentive for unrecognized clinics to become recognized, for clinics to advance to higher tiers of recognition, and for recognized clinics to accept higher numbers of Advanced Health members for primary care.

Advanced Health's quality and analytics teams will work to support clinics' PCPCH programs by revising some quality measure reports to align with the PCPCH quality measures and include all the information (numerator, denominator, rate) the clinics need to meet their PCPCH standard requirements.

As of December 31, 2021, 87% of Advanced Health members had a source of primary care with a PCPCH recognized clinic. In order to improve upon that rate, the goal is to provide technical assistance to clinics who are not currently PCPCH recognized. This includes but is not limited to; Coquille Valley Hospital, Ko-Kwel Wellness Center and Southern Coos Hospital. Each of these locations have experienced an increase in patient empanelment in 2021 due to an increase in number of primary care providers at these locations as well as the overall increase in Advanced Health membership due to the suspension of the redetermination process during the public health emergency declaration.

At the end of 2021, North Bend Medical Center's Coos Bay location has attested to remain a 5-Star PCPCH clinic pending a site visit in 2022 that has yet to be scheduled. Their satellite clinics in Bandon and Coquille aim to become tier 4 clinics with established integrated care management teams and the addition of behavioral health services in 2022. Work continues at satellite clinics in Myrtle Point and Gold Beach around care management with the aim to advance from tier 3 to tier 4 in the coming years.

Coast Community Health Center, a local Federally Qualified Health Center, is currently tier 4 and plans to attest to 5-star in Q3 of 2022 which will have a positive impact on the performance measure. Coquille Valley Hospital, after allowing their PCPCH recognition to lapse in mid-2021, also plans to start the recognition process again for their primary care clinic in early 2022. Discussion with Ko-Kwel Wellness Center, formerly known as the Coquille Indian Tribe Health Center, regarding becoming a PCPCH recognized clinic will start in early 2022. The Ko-Kwel Wellness Center has established dental and behavioral health services in addition to primary care services. After Waterfall Community Health Center's (another local FQHC) attestation to Tier 4 in 2021 they plan to re-attest for 5-Star in mid-2022.

In an effort to provide monthly metrics progress reports to our clinic partners in a timely manner as well as incorporating aspects of PCPCH we plan to deploy the provider facing portal that our third-party data collection vendor is working to establish. This portal will allow quality teams at our local clinics to access their clinic specific data on all the incentive measures on demand as well as allow them to generate and download their own gap lists for patient outreach and interventions for improvement. This provider portal aims to be fully operational including training by Q3 of 2022.

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

**Activity 1 description**: Establish and educate community clinics on provider portal for on-demand access to quality incentive measure progress reports and gap lists.

☒ Short term or ☐ Long term

| **Monitoring measure 1.1** | Establish provider portal through third-party data vendor (MedInsight) | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Provider portal not established or in use. | Provider portal established and clinics trained in how to use it. | 12/2022 | Monitoring usage by clinic-based Quality improvement teams | 12/2023 |

**Activity 2 description**: Monitor both the PCPCH tier levels of primary care providers in the Advanced Health network and the proportion of Advanced Health's membership assigned to PCPCH recognized clinics. Targets are set based on anticipated changes as the clinics achieve their goals for 2022 and 2023 PCPCH tier attainment. Advanced Health Quality staff will provide technical assistance and support as requested to help provider network organizations achieve their goals.

☐ Short term or ☒ Long term

| **Monitoring measure 2.1** | Monitor progress quarterly as part of the DSN Capacity reporting process. | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 87% of Advanced Health members receive primary care from a PCPCH recognized provider (12/2021) | 90% of Advanced Health members receive primary care from a PCPCH recognized provider | 12/2022 | 92% of Advanced Health members receive primary care from a PCPCH recognized provider | 12/2023 |
| 79.5%<br>**Preliminary rate**<br>PCPCH Enrollment Quality Measure<br>(CY 2021) | 84%<br>PCPCH Enrollment Quality Measure | 12/2022<br>(reported by OHA in 6/2021) | 86%<br>PCPCH Enrollment Quality Measure | 12/2023<br>(reported by OHA in 6/2024) |

## A. **Project short title**: Dual Eligible – Special Health Care Needs

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

If continued, insert unique project ID from OHA:

## B. **Components addressed**

i. Component 1: SHCN: Full benefit dual eligible
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The 2020 Compliance Monitoring Review (CMR) of Advanced Health's ICC program by the Health Services Advisory Group (HSAG) recognized the CCO's heavy investment in staff, software solutions, program development and implementation to meet the needs of our SHCN members. Advanced Health fully met all the review elements in the Coordination and Continuity of Care standard that related to members with SHCN. The HSAG CMR report also highlighted the newly implemented Activate Care software system which organized care coordination information and care plans and ensured timeframes were met by care coordinators. Activate Care also allows those care plans and coordination information to be shared with the Member directly as well as other members of the care team outside of Advanced Health.

Last year, Advanced Health's Intensive Care Coordination (ICC) team provided services and personalized care to approximately 350 members with Special Health Care Needs (SHCN). Furthermore, Advanced Health's ICC program submitted their first care coordination activities report for the second quarter period of 2021 to the Oregon Health Authority (OHA) and is presently awaiting feedback. In 2Q of 2021, some of the numerical highlights from the report were that Advanced Health's ICC team: identified 4845 members eligible for ICC services, served 169 members, and had 17 members that declined or refused ICC. Eighty nine percent of members were screened within the required ICC time frames and 97% members in Prioritized Populations were assessed for ICC within 10 days. Since that reporting period and due to statewide CCO feedback throughout 2021, OHA instituted a yearlong ICC Learning Collaborative in 2022 to discuss program models, ICC OAR interpretations, problem solve systematic issues and build a partnership of ICC teams to better serve our SHCN members. Advanced Health is an active participant in the ICC Learning Collaborative, and staff are presenting at the March 2022 meeting.

To improve access for our SHCN members, Advanced Health has either created and/or strengthened a myriad of referral pathways and community partnerships to better meet their complex health needs. Members are identified through a variety of established CCO mechanisms and entryway points into Intensive Care Coordination services. Through Advanced Health's Customer Service department, all newly enrolled Advanced Health members are screened with a health risk assessment (HRA) and given the opportunity to self-identify special health care needs for referral to intensive care coordination services. Also, Members can self-refer by calling Customer Service or be referred by primary care homes, LTSS case managers, health care professionals, social service agencies, family members, and/or caregivers. It is always Advanced Health's preference to identify eligible Members for Intensive Care Coordination at the time of enrollment through screening protocols, through annual re-assessment or Member request, rather than through triggering events such as a new hospital admission or recent homelessness. Nonetheless, triggering events also serve to create occasions for entry to Intensive Care Coordination. It should be noted that the greatest demand for ICC services originated from our community partners due to the pandemic impact on healthcare system, increased community awareness of the availability services staff and/or members themselves.

Each ICC member is assigned a Care Coordinator (such as a Traditional Health Worker or Registered Nurse) as a single and consistent point of contact. Member's assigned coordinator assists the member in identifying and resolving healthcare barriers from assessment information (PRAPARE), collaboration from the member, and additional information from their care team participants in case conferences such at Bay Hospital, individualized complex coordination meetings and/or collaborative problem-solving month meetings with Aging and People with Disabilities.

SHCN Member's care plans are built by Advanced Health care coordinators in Activate Care with an emphasis on using a comprehensive and wholistic approach. ICC teams members are encouraged to collaborate on plans depending upon the complex needs of the member such as medical, behavioral, and/or social. Care plans incorporate interdisciplinary goals, evidence of member participation, distinct roles for care team members and clear tracking of ICC time frames to

help remind Advanced Health coordinators of the necessary tasks to complete enrollment, intake, and healthcare specific goals. Current length of care on average in our program varies from short term to long term usually spanning a time frame of 3 to 18 months. If a healthcare or SDOH barrier is identified by the coordinator that requires a flex fund (flexible Health-Related Services spending) intervention, Advanced Health has developed an internal ICC flex fund process to reduce the barriers frequently encountered by our SHCN members.

For members with SHCN needing access to a specialist, determined through a comprehensive assessment by either the ICC Director and/or ICC program manager and noted to have ongoing special conditions requiring a course of treatment or regular care monitoring, Advanced Health will allow direct access to a specialist, at no cost to the member. The specialist should be appropriate for the member's condition and identified needs. The PCP can simply refer the member to the specialist without an authorization. The referring provider should also notify Advanced Health of the referral by submitting the Physician Authorization Form, found on Advanced Health's website, marking the SHCN Box at the top of the form and providing the name and contact information of the specialist. This will allow the creation of an authorization number to be provided to the specialist for billing purposes. This authorization will include pre-approved visits (i.e.6 visits in 6 months) allowing the member to establish with specialist and receive care.

Over the past two years, Advanced Health's ICC team has developed strong and valuable relationships internally and externally with medical, behavioral, and social service professionals to greatly improve coordination of care and discharge planning for dual eligible members. Currently, there are two dual eligible population groups being monitored by Advanced Health: a small population of members who are also enrolled with our affiliated Medicare Advantage (MA) Pacific Source plans, and the much larger Oregon Department of Human Services (ODHS) dual eligible population group. According to current CCO analysis of our dual eligible membership, 84% of the Advanced Health members receiving LTSS with APD are also dual eligible members, and 79% are full benefit dual eligible. Advanced Health calculates the LTSS FBDE population size is approximately 650 members.

Advanced Health care coordination staff meet regularly with Pacific Source MA case management staff to review cases for mutual FBDE members, identify any members with special health care needs, and address barriers to care.

To identify LTSS FBDE members in need of care coordination, ICC staff are consistently present at weekly hospital complex case meetings with Aging and Persons with Disabilities (APD) case managers; monthly Interdisciplinary Team (IDT) meetings with DHS APD case management, Coos Health and Wellness (Behavioral Health) and Area Agency on Aging (AAA) to discuss and problem solve the needs of dual eligible members. Progress is underway to further improve communication through developing a process to capture and communicate dual eligible member Collective Medical notifications (hospital event and skilled nursing facility) and increase bidirectional referrals between our agencies.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

In 2020, OHA provided guidance to CCOs on the development of a new and enhanced MOU partnership between Advanced Health and our local LTSS APD partners. The purpose of this MOU was to build on past partnerships, continue to improve outcomes for shared members; prioritize, coordinate, and align services tailored to LTSS and dual eligible members, establish process for bidirectional CCO and APD referrals; create mechanisms for shared accountability of care planning, care transition and communication; discharge follow up, ease for members navigating our healthcare system, utilize person-centered planning, and document our shared activities. Advanced Health's MOU focused on prioritization of our dual eligible members, establishing interdisciplinary team (IDT) meetings, developing and sharing of care plans, monitoring transition of care practices and creating collaborative communication. The goal for Advanced Health is to improve the quality of our MOU metrics by prioritizing SHCN LTSS and dual eligible members, maintain consistent IDT meetings, increase bidirectional referrals, develop, and share care plans, monitor transition of care practices and greatly improve our systematic review of Collective Medical notifications that result in follow up or consultation with APD.

In addition to the Advanced Health's partnership with DHS APD, Advanced Health also maintains an agreement with Pacific Source to monitor the Medicare Advantage (MA) dual eligible population. Overall priorities for the Advanced Health team are to work with our MA Plan partners to evaluate if Pacific Source should file to have a DSNP plan, increase the number of CCO members enrolled in Pacific Source MA plans and utilize technology such as Collective Medical notifications and potentially Activate Care to enhance care coordination. Improvement plans are underway in discussing ways to enhance or integrate member communications, explore how to obtain denial notices from Pacific Source to assist with coordination of care for members; process to share member care plans from Collective Medical Hospital Event Notifications (HEN) and Skilled Nursing Facility (SNF), Health Risk Assessment (HRA) member information with Pacific Source staff, monitor utilization of preventative services for dual eligible members, promote integrated care and continuation of quarterly meetings between the CCO and Pacific Source to discuss any dual eligible member needs, barriers and develop improvements in access to community services for the dual eligible population.

E. **Brief narrative description**:

Since 2021, Advanced Health has been working on developing points of contact with DHS APD at a variety of meetings to identify LTSS dual eligible members in need of additional support from intensive care coordination. Historically, meetings have been held on a regular basis at Bay Area Hospital to address patients (which include full benefit dual eligible members with SHCN) that have complex medical, behavioral health, and SDOH needs. Additional work was done to create a new monthly meeting between Advanced Health, DHS APD, Coos Health and Wellness (behavioral health) and AAA to further enhance our collaborative partnerships to problem solve for FBDE SHCN members, as well as provide a new bidirectional pathway to refer members to each other. Dual eligible members' wholistic needs can now be address since all the relevant agencies are present to discuss medical, behavioral health and SDOH. After our work at the end of 2021, we have identified several areas of improvement such as increasing the sharing of LTSS members prioritization data, further developing our process to monitor hospital event and skilled nursing facility notifications, increasing the participation of LTSS dual eligible members in their own care, and increasing the number of transitions of care where discharge communication was completed prior to discharge.

Also in 2021, Advanced Health designed a new process to identify and communicate Pacific Source dual eligible patient needs. Advanced Health built a Pacific Source (PS) group in Collective Medical to monitor MA member HEN and SNF activity. Presently each identified MA member is tagged, assigned to a PS group and monitored by our nursing case manager for follow up care coordination with PS. Our PS coordinator notifies PS by encrypted email of the occurrence of a SNF or HEN notification from the PS group. Depending on the member's need(s), a care coordination meeting can be scheduled between Advanced Health and PS to problem solve solutions. PS agreed to identify MA members as either having SHCN or LTSS needs by screening each MA member telephonically and/or utilizing the LTSS tag in the 834-eligibility file sent by Advanced Health. If PS identifies a member having SHCN and/or LTSS follow up, they will send a request for review by the Advanced Health ICC program manager. As of 2022, each identified MA member can be discussed at Advanced Health's current monthly IDT meeting with DHS APD, AAA and our behavioral health partner(s). Additional Dental needs will be referred to Advanced Health's contractor, Advantage Dental, for case management. Behavioral health needs are referred to either Coos Health and Wellness or ADAPT, Advanced Health's contractors for behavioral health care coordination. Social needs can be addressed by Advanced Health ICC traditional health workers (THWs). If a MA member is screened and enrolled into Advanced Health's ICC or TOC (Transitions of Care) programs, then a care plan will be created in Advanced Health's care coordination software program, Activate Care, which provides a cloud based comprehensive and HIPAA compliant approach in organizing care coordination activities and permissioned access to the real time care coordination plan (member and approved Care Team professionals can access electronically). Advanced Health and PS have agreed to meet quarterly to continue collaboration efforts, identify process issues and/or areas of improvement and discuss any unresolved MA member matters.

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

**Activity 1 description:** Prioritization of high needs members

☒ Short term or ☐ Long term

| **Monitoring measure 1.1** | Number of LTSS members whose prioritization data was shared | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 18 | 22 | 6/30/22 | 24 | 12/30/22 |
| **Monitoring measure 1.2** | Number of bidirectional referrals | | | |
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 3 | 4 | 6/30/22 | 5 | 12/30/22 |

**Activity 2 description**: Collaborative communication tools and processes

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement**: Monitor Collective Medical Hospital Event Notifications (HEN) and Skilled Nursing Facility (SNF) notifications for potential referral to intensive care coordination services.

| **Monitoring measure 2.1** | Process for monitoring HEN and SNF notifications | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| Need to develop process to monitor HEN and SNF notifications systematically | Submit finalized process to OHA | 4/2022 | Fully implement process | 10/2022 |

**Activity 3 description**: Number of LTSS members participating in Interdisciplinary (IDT) care teams

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement**: Increase participation of LTSS members in care team meetings

| **Monitoring measure 2.1** | Members participating in IDT meetings | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 0/month | 1/month | 6/30/2022 | 2/month | 12/31/2022 |

**Activity 4 description**: Transitional Care Practices

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement**: Increase number of transitions where CCO communicated about discharge planning with APD office prior to discharge/transition

| **Monitoring measure 2.1** | Number of TOC member communications | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 1.5/month | 2/month | 6/30/2022 | 3/month | 12/31/2022 |

**Activity 5 description**: Pacific Source dual eligible member collaboration

☒ Short term or ☐ Long term

**Monitoring activity 2 for improvement**: Maintain quarterly and ad-hoc communication between CCO and Pacific Source staff

| **Monitoring measure 2.1** | **Maintain CCO and Pacific Source IDT 100% attendance rate** | | | |
|---|---|---|---|---|
| **Baseline or current state** | **Target/future state** | **Target met by (MM/YYYY)** | **Benchmark/future state** | **Benchmark met by (MM/YYYY)** |
| 1 meeting/quarter | 1 meeting/quarter | 6/30/2022 | 1 meeting/quarter | 12/31/2022 |

## Section 2: Discontinued Project(s) Closeout

A. Project short title: Reducing Preventable Emergency Department Visits
B. Project unique ID (as provided by OHA): 7
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): Continued reduction in Emergency Department utilization for the fourth consecutive year, although 2020 and 2021 rates were dramatically affected by Covid-19. Interventions put in place during this project will continue.

A. Project short title: Social Determinants of Health (PRAPARE) Screening for Intensive Care Coordination
B. Project unique ID (as provided by OHA): 9
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): Advanced Health's Intensive Care Coordination program continues to increase the number of members in care every year. The use of PRAPARE as a screening tool upon intake Is well established and is an effective tool to aid in crafting a member-centered care plan. Aggregate results from the PRAPARE screening are also used in setting spending priorities for Health-Related Services funding.

## Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's quality improvement committee documentation as outlined in TQS guidance.
    1. Advanced Health Clinical Practice Guidelines Policies and Procedures FINAL 20200723
    2. CAP Charter January 2021
    3. GR-Grievance System_Policy and Procedure Manual_v7_08192021_FINAL_signed
    4. Interagency Quality Committee Charter 2021
    5. MS-Member Rights Protections and Responsibilities_Policy and Procedures_03162020_FINAL_signed
    6. November 2021 Interagency Delegate Quality Meeting Minutes

7. October 2021 Interagency Delegate Quality Meeting Minutes
8. Q-Advanced Health QAPI_Policy and Procedure_03152021_FINAL_signed
9. September 2021 Interagency Delegate Quality Meeting Minutes

B. OPTIONAL: Supporting information

- 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.
- Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Click or tap here to enter text.

# Clinical Practice Guidelines Policy and Procedures

| | |
|---|---|
| Company: Advanced Health & SW Oregon IPA, Inc | Approved by: Kent Sharman, MD<br>Title: Chief Medical Officer |
| Department: Compliance | |
| Policy: Clinical Practice Guidelines: Selection and Dissemination | Approved Date: 7/23/2020 |
| | Revision Dates: 5/5/2015, 4/28/2017, 4/23/2018, 5/9/2018, 7/19/2019, 7/23/2020 |

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## 1.0 PURPOSE

1.1 Advanced Health uses evidence-based practice guidelines to promote the highest quality clinical and health outcomes for Advanced Health Members.

## 2.0 SCOPE

2.1 This policy and procedure applies to Advanced Health network providers, staff, and Members.

## 3.0 Policy

3.1 Advanced Health shall adopt practice guidelines, specified in 42 CFR 438.236 (b)(c)(d), that are based on valid and reliable clinical evidence or a consensus of health care professionals and that consider the needs of Members.

3.2 Advanced Health shall adopt these guidelines in consultation with network providers and the Clinical Advisory Panel.

3.3 Practice guidelines shall be reviewed at least annually and updated as appropriate.

3.4 Advanced Health shall disseminate the practice guidelines to all affected providers and, upon request, to Members, Potential Members, or Member Representatives.

3.5 Advanced Health's decisions for utilization management, Member education, coverage of services, or other areas to which the guidelines apply, must be consistent with the adopted practice guidelines.

## 4.0 Procedure

4.1 Clinical practice guidelines may be recommended by the Advanced Health Clinical Advisory Panel, the Advanced Health Board of Directors, the Advanced Health Pharmacy and Therapeutics Committee, Physical Health providers, Oral health providers, Substance Use Treatment providers, Behavioral Health providers, or any provider in the Advanced Health network. The Advanced Health Chief Medical Officer, Executive Program Director, or Interagency Quality Committee may also recommend clinical practice guidelines for the improvement of health outcomes for Advanced Health Members based on prevalent conditions in the community and other identified needs.

4.2 The Advanced Health Clinical Advisory Panel reviews recommendations for clinical practice guidelines and determines which guidelines to adopt.

4.3 Previously adopted guidelines are reviewed annually by the Clinical Advisory Panel to determine whether to continue adoption or if revisions are needed.

4.4 Adopted guidelines, whether new or revised, are disseminated to:

4.4.1 All affected providers through the Advanced Health website and may be disseminated by other methods such as provider education, new provider orientation, provider manual, email, or newsletter

4.4.2 Members, Potential Members, or Member Representative upon request, by a method determined to be accessible by the member. Methods may include the Advanced Health website, member education, mail, email, or in the Advanced Health office or provider office.

4.5 Advanced Health staff and contracted organizations that perform utilization management functions will make utilization management and coverage decisions consistent with the adopted clinical practice guidelines.

4.6 Advanced Health monitors data from the Member Grievance system, including Notices of Adverse Benefit Determination, Requests for Appeal, and Member Complaints to ensure coverage decisions and utilization management decisions are consistent with the adopted clinical practice guidelines.

## 5.0 Reference Sources

5.1 OAR 410-120-0000 (92); OHA CCO Contract Exhibit B- Part 4(11) - Providers and Delivery System; 42 CFR 438.236 (b)(c)(d)

## 6.0 Responsibilities

6.1 Advanced Health Clinical Advisory Panel reviews and adopts evidence-based clinical practice guidelines

6.2 Chief Medical Officer ensures clinical practice guidelines are disseminated to providers in the Advanced Health network.

6.2 Utilization management staff make authorization and coverage decisions consistent with the adopted clinical practice guidelines.

6.3 Grievance System Coordinator monitors data from the grievance system to ensure coverage decisions are consistent with the adopted clinical practice guidelines. The Grievance System Coordinator notifies the Chief Medical Officer of any discrepancies or trends.

## 7.0 Related Documents

| # | Doc # | Document Title |
|---|---|---|
| 7.0 | | |
| 7.2 | | |

## 8.0 Acronyms and Definitions

8.1 Evidence-Based Medicine - the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and

compassionate evaluation [sic] of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings. OAR 410-120-0000 (92)

## 9.0 Attachments

9.1

## 10.0 Approvals

Document Owner: Kent Sharman, MD, Chief Medical Officer — Name, title

Collaborators: Anna Warner, Executive Program Director

Approvals

- Committees: Advanced Health Clinical Advisory Panel — Name, title
- Signers:

Original Effective Date: 5/5/2015

Revision Date: 4/28/2017, 4/23/2018, 5/9/2018, 7/19/2019, 7/23/2020

Review Date:

| | |
|---|---|
| **Title:** | **CLINICAL ADVISORY PANEL CHARTER** |
| **Date Chartered:** | September 2013 |
| **Timeline:** | This is a standing committee |
| **Purpose:** | The Clinical Advisory Panel exists to provide a platform for collaboration and coordination between Advanced Health's leadership, delegate organizations, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care and cost efficacy. The Clinical Advisory Panel provides a clinical perspective to Advanced Health. This committee is responsible for the development of recommendations regarding the use of health information to improve workflow and clinical decision making. |
| **Goals:** | 1. Work collaboratively to build relationships and systems that support Advanced Health members and providers by designing, measuring, assessing and improving performance in the areas of medical management, medical outcomes, cost efficiency, operations, and member engagement.<br>2. Coordinate with community leadership to define and advocate for:<br>• The clinical delivery of services<br>• The optimal delivery of care<br>• Innovative cost saving programs<br>• Identify how to reduce overutilization of costly services<br>• Quality performance measures / metrics<br>• Evidence based practices<br>• Provider development<br>• Provider satisfaction / wellness<br>• Provider input to the CCO Board regarding clinical credentialing<br>• Electronic Medical Record / Health Information Exchange<br>• Equitable access to services and health outcomes<br>3. Shall make recommendations to the Advanced Health Board regarding:<br>• Implementation of Clinical Guidelines<br>4. Identify barriers and gaps to achieving transformation and improvement.<br>5. Assuring evidence based best practices and/or community standards are adopted and utilized by the CCO.<br>6. Analyzing utilization patterns, data and metrics, including identification of patterns. When opportunities to improve clinical outcomes are noted, the CAP will be responsible for creating strategies to address deficiencies and setting targets for ongoing performance.<br>7. Evaluate coordination and integration of services within the provider network, including transitions of care. When opportunities are identified, the CAP will work on strategies to enhance coordination and integration, and optimal transition.<br>8. Evaluation and monitoring of Performance Improvement Projects (PIPs).<br>9. Monitoring the expansion and development of Patient Centered Primary Care Homes in the Primary Health network.<br>10. Oversight of a portion of the CCO's Annual Work Plan |

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| | 11. Provide oversight of the CCO's Quality Improvement Plan Effectiveness. |
| **Committee Chair:** | The committee will be chaired by Advanced Health's Chief Medical Officer |
| **Committee Membership** | Advanced Health's Chief Medical Officer, Advanced Health's CEO, Advanced Health's Chief Operating Officer, Advanced Health's Director of Quality and Accountability, Behavioral Health Representatives, Physical Health Representatives, and an Oral Health Representative<br>Additional members will be added as needed.<br>** CAP meetings are closed to the public. |
| **Committee Members' Responsibilities:** | • Actively participate in meetings to achieve the committee's goals<br>• Work effectively with other committee members<br>• Act as role models to inspire their organization's engagement<br>• Provide support to the Advanced Health Board of Directors<br>• The CAP will clarify its decision-making model.<br>51% of CAP members constitutes a quorum. A majority of voting members present after a quorum has been established will be adequate to make all decisions. |
| **Meeting Frequency:** | Full committee will meet the 2nd and 4th Fridays for 1 hour to accomplish the purpose of the committee |
| **Term:** | Ongoing |
| **Review Charter:** | The Charter will be reviewed annually by the CAP members. Any amendments will be brought to the Advanced Health Board for final approval. |
| **Date(s) Revised:** | February 2016, April 2017, July 2018, January 2021 |

# Inter-Agency Quality Committee Charter

| | |
|---|---|
| **Title:** | **Interagency Quality Committee** |
| **Date Chartered:** | September 2014 |
| **Time Line:** | Standing Committee |
| **Purpose:** | The Interagency Quality Committee exists to provide a platform for collaboration and coordination between Advanced Health's leadership, provider network, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy. |
| **Goals:** | 1. Work collaboratively to build relationships and systems that support Advanced Health members and providers by designing, measuring, evaluating, and improving the effectiveness of quality management systems;<br>2. Work collaboratively to achieve OHA metrics;<br>3. Identify opportunities for practice/agency level health system transformation and improvement;<br>4. Identify barriers and gaps to achieving transformation and improvement;<br>5. Identify and implement actions to promote improved processes within the service delivery system;<br>6. Participate in the development and implementation of Advanced Health's annual Quality Improvement Strategy and Work Plan;<br>7. Advise, evaluate, and support Advanced Health's strategic initiatives and goals related to quality, access, and process improvement. Evaluation may include monitoring with the following actions:<br>• Clinical record keeping/documentation review<br>• Utilization review including in and out of network, and emergency services<br>• Referrals<br>• Comorbid conditions<br>• Prior authorizations and medication review<br>• Encounter data regarding member disenrollment and access to care and services |

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| | 8. Recommend standards and strategies for quality review of the following delegated services:<br>• Mental Health Services<br>• Public Health Services' Home Visiting Programs<br>• Addictions Services<br>• Oral Health<br>• Transportation Services<br>9. Oversee implementation of Advanced Health's quality review of delegated services; grievance and appeals<br>10. Monitor Non-Medical/Flexible Fund expenditures for compliance with established policy and procedure and recommend changes as needed; |
| **Committee Chair:** | The committee will be chaired by Advanced Health's Director of Quality |
| **Committee Membership** | Advanced Health's Medical Director, Director of Behavioral Health, Director of Quality, Quality Improvement Specialist, Coos Health and Wellness, Curry Community Health, ADAPT, Advantage Dental, Bay Area Hospital, Waterfall Community Health Center, Coast Community Health Center, North Bend Medical Center, Bay Clinic, Coquille Valley Hospital, Southern Coos Hospital, Curry Health Network/Curry General Hospital, Community Advisory Council representatives, when invited, and other community providers as invited or interested. |
| **Committee Members' Responsibilities** | • Actively participate both in and out of meetings to achieve the committee's goals<br>• Work effectively with other committee members<br>• Act as role models to inspire their organization's engagement<br>• Participate in External Quality Review processes when requested |
| **Meeting Frequency:** | Full committee will meet monthly for 1 hour or more often if necessary to accomplish the purpose of the committee<br><br>Time framed work groups may be convened to focus on a particular objective or project |
| **Term** | Ongoing |
| **Review Charter:** | Annually |
| **Date(s) Revised:** | March 2016, May 2017, February 2018, November 2019, May 2020, May 2021 |

# Member Rights, Protections and Responsibilities Policies and Procedures

| | |
|---|---|
| Company:<br>Advanced Health | Approved by: M. Hale<br>Title: CCO<br>Drafted by: M. Hale<br>Title: CCO |
| Department: Compliance | |
| Member Rights, Protections and Responsibilities | Approved Date: March 16, 2020 |
| | Revision Dates: |

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## 1.0 Purpose

**1.1** The purpose of these Member Rights, Protections and Responsibilities Policies and Procedures is to delineate how Advanced Health will ensure compliance with applicable rules and regulations relating to such rights, protections and responsibilities.

## 2.0 Scope

**2.1** These Policies and Procedures apply to Advanced Health, and by extension to Privileged Providers, other Network Providers and other contracted entities that interact with Members on behalf of Advanced Health.

## 3.0 Acronyms and Definitions

**3.1** "Contract" means the CCO 2.0 Contract.

**3.2** Capitalized terms not otherwise defined in this Policy and Procedure shall have the meaning as defined in the Contract.

**3.3** "Member" has the same meaning as defined in the CCO 2.0 Contract and includes potential members.

**3.4** "Member Rights, Protections and Responsibilities", "Member Rights" and "Member Rights and Responsibilities" have the same meaning as those rights, protections and responsibilities set forth in 42 CFR §438.100, OAR 410-141-3590 and the Contract, and each of these terms.

3.4.1 More specifically, these guaranteed rights and protections include the right to:

3.4.1.1. Be treated with dignity and respect;

3.4.1.2. Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the Member's care team, including Providers and community resources appropriate to the Member's needs;

3.4.1.3. Choose a Primary Care Provider (PCP) or service site and to change those choices as permitted in Advanced Health's administrative policies;

3.4.1.4. Refer oneself directly to Behavioral Health or family planning services without getting a referral from a PCP or other Participating Provider;

3.4.1.5. Have a friend, family member, member representative, or advocate present during appointments and other times as needed within clinical guidelines;

3.4.1.6. Be actively involved in the development of their Treatment Plan;

3.4.1.7. Be given information about their condition and Covered and Non-Covered services to allow an informed decision about proposed treatments;

3.4.1.8. Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;

3.4.1.9. Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

3.4.1.10. Have written materials explained in a manner that is understandable to the Member and be educated about the coordinated care approach being

used in the community and how to navigate the coordinated health care system;

3.4.1.11. Receive culturally and linguistically appropriate services and supports in locations as geographically close to where Members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

3.4.1.12. Receive oversight, care coordination and transition and planning management from Advanced Health within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

3.4.1.13. Receive necessary and reasonable services to diagnose the presenting condition;

3.4.1.14. Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

3.4.1.15. Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

3.4.1.16. Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the Member's care team to provide cultural and linguistic assistance appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services;

3.4.1.17. Obtain Covered Preventive Services;

3.4.1.18. Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;

3.4.1.19. Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in Advanced Health's referral policy;

3.4.1.20. Have a clinical record maintained that documents conditions, services received, and referrals made;

3.4.1.21. Have access to one's own clinical record, unless restricted by statute;

3.4.1.22. Transfer of a copy of the clinical record to another provider;

3.4.1.23. Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;

3.4.1.24. Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or State regulations;

3.4.1.25. Be able to make a complaint or appeal with Advanced Health and receive a response;

3.4.1.26. Request a contested case hearing;

3.4.1.27. Receive a notice of an appointment cancellation in a timely manner; and

3.4.1.28. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

3.4.2 Additional rights guaranteed under Contract, and federal and State law include the right to:

3.4.2.1.A second opinion from a Health Care Professional within the Provider Network or outside the Provider Network, at no cost to the Members;

3.4.2.2.Exercise their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A and to report a complaint of discrimination by contacting the Contractor, OHA, the Bureau of Labor and Industries or the Office of Civil Rights;

3.4.2.3.Receive written notice of Advanced Health's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all Applicable Laws including Title VI of the Civil Rights Act and ORS Chapter 659A;

3.4.2.4.Equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270;

3.4.2.5.OHA certified or qualified health care interpreter services available free of charge to each Potential Member and Member. This applies to all non-English languages and sign language, not just those that OHA identifies as prevalent;

3.4.2.6.Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Advanced Health's plan and develop and provide written information materials and educational

programs consistent with the requirements of OAR 410-141-3280124F1 and 410-141-3300;

3.4.2.7. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language, and ability to understand;

3.4.2.8. To request and receive a copy of their own Health Record, (unless access is restricted in accordance with ORS 179.505 or other Applicable Law) and to request that the records be amended or corrected as specified in 45 CFR Part 164;

3.4.2.9. Be furnished by Advanced Health the information specified in 42 CFR §438.10(f)(2)-(3), and 42 CFR §438.10(g), if applicable, as specified in the CFR within thirty (30) days after Advanced Health receives notice of the Member's Enrollment from OHA within the time period required by Medicare. Advanced Health shall notify all Members of their right to request and obtain the information described in this section at least once a year;

3.4.2.10. Access Covered Services which at least equals access available to other persons served by Advanced Health;

3.4.2.11. Exercise Member's rights, and that the exercise of those rights will not adversely affect the way Advanced Health, its staff, Subcontractors, Participating Providers, or OHA, treat the Member. Advanced Health shall not discriminate in any way against Members when those Members exercise their rights under the OHP;

3.4.2.12. Any cost sharing authorized under the Contract for Members is in accordance with 42 CFR §447.50 through 42 CFR §447.90 and the applicable Oregon Administrative Rules;

3.4.2.13. Be notified of Member's responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230;

3.4.2.14. If available and upon request by Member, utilize electronic methods to communicate with and provide Member information;

3.4.2.15. Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR §438.206 through 42 CFR §438.210);

3.4.2.16. Be provided information to help understand the requirements and the benefits of the Plan; and

[1] New OAR 410-141-3580

3.4.2.17. Exercise his or her rights and the exercise of those rights will not adversely affect the way Advanced Health, its Network Providers, or the State Medicaid agency treats the Member.

3.4.3 Advanced Health Members shall have the following responsibilities:

3.4.3.1. Choose or help with assignment to a PCP or service site;

3.4.3.2. Treat Advanced Health, Providers, and clinic staff members with respect;

3.4.3.3. Be on time for appointments made with Providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;

3.4.3.4. Seek periodic health exams and preventive services from the PCP or clinic;

3.4.3.5. Use the PCP or clinic for diagnostic and other care except in an emergency;

3.4.3.6. Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

3.4.3.7. Use urgent and emergency services appropriately and notify the Member's PCP or clinic within 72 hours of using emergency services in the manner provided in the Advanced Health's referral policy;

3.4.3.8. Give accurate information for inclusion in the clinical record;

3.4.3.9. Help the Provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;

3.4.3.10. Ask questions about conditions, treatments, and other issues related to care that is not understood;

3.4.3.11. Use information provided by Advanced Health Providers or care teams to make informed decisions about treatment before it is given;

3.4.3.12. Help in the creation of a Treatment Plan with the provider;

3.4.3.13. Follow prescribed agreed upon treatment plans and actively engage in their health care;

3.4.3.14. Tell the Provider that the Member's health care is covered under the OHP before services are received and, if requested, show the Provider the Division Medical Care Identification form;

3.4.3.15. Tell the Department or Authority worker of a change of address or phone number;

3.4.3.16. Tell the Department or Authority worker if the Member becomes pregnant and notify the worker of the birth of the member's child;

3.4.3.17. Tell the Department or Authority worker if any family members move in or out of the household;

3.4.3.18. Tell the Department or Authority worker if there is any other insurance available;

3.4.3.19. Pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

3.4.3.20. Pay the monthly OHP premium on time if so required;

3.4.3.21. Assist Advanced Health in pursuing any third-party resources available and reimburse Advanced Health the amount of benefits it paid for an injury from any recovery received from that injury; and

3.4.3.22. Bring issues or complaints or grievances to the attention of Advanced Health.

## 4.0 Policies

**4.1** Advanced Health shall remain steadfast in its commitment towards ensuring its Members maintain access and receive treatment in a manner consistent with 42 CFR 438.100, OAR 410-141-3590 and Exhibit B Part 3 of the CCO 2.0 Contract, and will comply with all other federal and State laws that pertain to Member Rights, Protections and Responsibilities including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education activities); Titles II and III of the Americans with Disabilities Act; and, Section 1557 of the Patient Protection and Affordable Care Act.

**4.2** Advanced Health will ensure communication of Member Rights, Protections and Responsibilities to its Members, Subcontractors, including Network Providers, and employees.

**4.3** Advanced Health shall monitor compliance with this Member Rights, Protections and Responsibilities Policy and Procedure.

**4.4** Advanced Health shall follow its policies and procedures for the implementation and enforcement of any corrective action plans or disciplinary actions.

## 5.0 Procedures

**5.1** Advanced Health meets its commitment to comply with all requirements outlined in Policy 5.1 by having a system with dedicated staff charged with the review and oversight of Member Rights, Protections and Responsibilities. While all staff are responsible for ensuring that our Members are treated in a manner consistent with their rights, the staff with primary responsibility for review and oversight of Member Rights, Protections and Responsibilities are:

5.1.1 The Chief Executive Officer—Primary responsibility for enforcement of any zero tolerance, or related action resulting in the termination of a contract or employee.

5.1.2 The Chief Compliance Officer—Primarily responsibility for auditing and monitoring of Advanced Health and its Subcontractors, including its Provider Network, and implementing appropriate corrective action as necessary up to, and including, termination of contractual agreements.

5.1.3 The Chief Medical Officer— Shared or primary responsibility for monitoring and overseeing any disciplinary action process of a Network Provider.

5.1.4 The Chief Operating Officer— Shared or primary responsibility for monitoring and overseeing any disciplinary action process of a Network Provider.

5.1.5 HR Generalist—Primary responsibility for monitoring employees, and overseeing any corrective or disciplinary action of employee(s)

5.1.6 Executive Program Director—Oversight and primary responsibility for all Grievance and Appeals monitoring and reporting processes. Primary responsibility for overseeing matters elevated through customer service monitoring activities.

5.1.7 Regulatory Compliance Committee—Primary body charged with oversight of all governance activities, including oversight of any corrective action process and monitoring to ensure corrective actions plans are closed timely.

**5.2** Member Rights and Responsibilities will be communicated in, at a minimum, the following ways:

5.2.1 Communication to Members. The Director of Member Services is primarily responsible for communicating Member Rights, Protections and Responsibilities by ensuring that:

5.2.1.1. Members receive the Member Handbook, which includes Member Rights, Protections and Responsibilities within thirty (30) days after notification from OHA of the Member's Enrollment and at least annually thereafter;

5.2.1.2. Advanced Health's Member Handbook is maintained and prominently displayed at Advanced Health's front desk, or within the Member waiting area;

5.2.1.3. Paper and electronic copies of the Member Handbook are available upon request to Members;

5.2.1.4. An electronic copy of the Member Handbook is prominently displayed on Advanced Health's website; and

5.2.1.5. Customer service staff are well-versed in Member Rights, Protections and Responsibilities and assist Members over the phone who may have questions regarding their rights and responsibilities.

5.2.2 Communication to Subcontractors. The Chief Compliance Officer is primarily responsible for communicating Member Rights, Protections and Responsibilities

to its Network Providers, Privileged Providers and other Subcontractors who interact with our Members by ensuring that:

5.2.2.1. Contractual agreements include Member Rights, Protections and Responsibilities and the responsibilities of the Subcontractors to promote and honor those rights during their interactions with the Members;

5.2.2.2. Advanced Health's Provider Handbook, which includes Member Rights, Protections and Responsibilities, is given to each new Provider, either electronically or paper form, is electronically available on Advanced Health's website, and available upon request; and

5.2.2.3. Questions that Subcontractors may have regarding Member Rights, Protections and Responsibilities are promptly answered.

5.2.3 Communication to Employees. The Human Resource Generalist is primarily responsible for communicating Member Rights, Protections and Responsibilities to Advanced Health employees by ensuring that:

5.2.3.1. Training on Member Rights, Protections and Responsibilities is completed upon hire and at least annually thereafter for employees of Advanced Health;

5.2.3.2. A log is maintained documenting the completion of such training; and

5.2.3.3. Additional training is completed as needed as part of employee coaching or corrective action.

5.2.4 Communication to Provider Network. The Chief Medical Officer is primarily responsible for promoting Member Rights, Protections and Responsibilities within the Provider Network by ensuring that:

5.2.4.1. He or she promotes Member Rights, Protections and Responsibilities within the Provider Network, and educates fellow Providers by reinforcing our responsibilities and expectations during interactions with other Providers; and

5.2.4.2. Additional training and counseling, as applicable, is provided to those Providers who may not demonstrate a comprehensive understanding of Member Rights, Protections and Responsibilities.

**5.3** Compliance with this Member Rights, Protections and Responsibilities Policy and Procedure will be monitored through at least the following mechanisms:

5.3.1 Quality Monitoring. Advanced Health's Quality Department, under the direction of the Executive Program Director, monitors and responds to Member Grievances, in accordance with Advanced Health's Grievance and Appeals Policies and Procedures, and reports Grievances and Appeals to OHA in accordance with OHA requirements.

5.3.1.1. Grievances involving potential violations of Member Rights are reported to the Chief Compliance Officer for further investigation and response, as needed.

5.3.2 Contracts Monitoring. Annual review of Subcontractor performance includes a review of Member Rights processes.

5.3.3 Customer Services. Potential violations of Member Rights, Protections and Responsibilities are generally identified through Member Complaints, and are investigated and acted upon in accordance with Advanced Health's Grievance and Appeals Policies and Procedures.

5.3.4 Claims Post-Payment Integrity and Member Survey Letters. As part of its Post-Payment Integrity Review processes, Advanced Health monitors its Member survey letters for indications of potential, suspected or likely Member Rights, Protections and Responsibilities violations.

**5.4** Corrective action plans and disciplinary actions will be in accordance with the:

5.4.1 Employee Handbook, Supervisor Manual and applicable Human Resource Policies and Procedures;

5.4.2 The Compliance Manual and related Fraud, Waste and Abuse Policies and Procedures;

5.4.3 The Contracting Manual Policies and Procedures; and

5.4.4 Terms of applicable Subcontract agreements.

## 6.0 Reference Sources

**6.1** 42 CFR §438.100 and *et. seq*.

**6.2** 42 CFR §§447.50 through 447.90

**6.3** 42 CFR Part 80 (Title VI of the Civil Rights Act of 1964)

**6.4** 45 CFR Part 91 (Age Discrimination Act of 1975)

**6.5** The Rehabilitation Act of 1973

**6.6** Title IX of the Education Amendments of 1972

**6.7** Titles II and III of the Americans with Disabilities Act

**6.8** Section 1557 of the Patient Protection and Affordable Care Act

**6.9** ORS § 417.270

**6.10** ORS § 127.505 through 127.660.

**6.11** OAR 410-141-3590.

**6.12** CCO 2.0 Contract, Exhibit B, Part 3.

## 7.0 Related Documents

**7.1** Employee Handbook.

**7.2** Supervisor Manual

**7.3** Provider Handbook.

**7.4** Compliance Plan.

**7.5** Fraud, Waste and Abuse Policies and Procedures.

**7.6** Grievance and Appeals Policies and Procedures.

**7.7** Advance Directives Policies and Procedures.

**7.8** Behavioral Health Policies and Procedures.

**7.9** Care Coordination/Intensive Care Coordination Policies and Procedures.

## 8.0 Attachments

**8.1** None

## 9.0 Approvals

| | |
|---|---|
| Document Owner: | Michael Hale<br>Name |
| Approved: | ***Michael C. Hale***<br>Signature<br>Title: Chief Compliance Officer<br>Date: March 16, 2020 |
| Effective Date: | March 16, 2020 |
| Review Schedule:<br>(Check) | Annual: _____<br>Bi-Annual: _____ |
| Revision Dates: | 1. _____<br>2. _____<br>3. _____<br>4. _____ |

# Interagency Quality Committee Minutes

**November 4th, 2021**

| Attendance | | | |
|---|---|---|---|
| X | Amanda McCarthy, Quality Manager, Advanced Health | X | Jim Gardner, Chief Operating Officer, Advanced Health |
| | Anna Warner, Director of Quality, Advanced Health | X | Jerry O'Sullivan, ADAPT |
| | Belle Shepherd, Innovator Agent, OHA | | Marla Smith, Compliance Officer, Advanced Health |
| | Lindsey Tyner, Quality Improvement Coordinator, NBMC | | Rosie Revelle, Office Manager, Dr. Mike & Friends |
| | Tim Novotny, Bay Cities Brokerage/Ambulance | | Dawn Gray, Chief Operating Officer, Coast Community Health |
| | Laresa Rowden, Quality Improvement Coordinator, Bay Clinic | X | Lisa Castle, Quality Improvement Specialist, Advanced Health |
| | Leah Lorincz, Advanced Health RN Director of Member Services | | Tom Sorrells, Medical Director, Adapt |
| X | Sarah Cornelison, Bay Clinic | | Debby Allen, QST, NBMC |
| X | Jamilah Mooney, Coos Health & Wellness | | Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction |
| | Devan Martin, Quality, NBMC | | Jessica Foster, QI Specialist, Coast Community Health |
| X | Mari Stout, ADAPT | | Ana Leypoldt, Coos Health and Wellness |
| | Exalena Dayley, Quality Improvement Specialist, Waterfall | | Martina Rodman, NBMC |
| X | Molly Johnson, Advantage Dental | | Geanna Berrier, Care Management, NBMC |
| | Devan Martin, Trainer, NBMC | | Alyssa Kelley, Trainer, NBMC |
| | Nina, Bay City Brokerage/Ambulance | | Karen Stafford, Southern Coos |
| | Dee Roberson, Dr. Mike & Friends | | Jane Walters, NBMC |
| | Ross Acker, Advanced Health Director of Care Coordination | | Kent Sharman MD, Chief Medical Officer, Advanced Health |
| X | Jamie Schultz, Chief Quality Administrator, Waterfall | | Lela Wells, Advanced Health |
| | Heather Garrett, Bay Clinic | X | Brandie Feger, Director of Pharmacy, Advanced Health |

# Interagency Quality Committee Minutes

**November 4th, 2021**

| TOPIC | DISCUSSION / INFORMATION | ACTION REQUIRED Person Responsible |
|---|---|---|
| 1.0<br>Call to Order / Introductions | • The meeting started a bit late at 10:33 am by Lisa Castle.<br>• Roll call via Microsoft Teams/phone.<br>• Attendees reviewed the minutes from October 2021 and approved them at 10:37 am. | |
| 2.0<br>2021 CCO Metric Performance Update | • Amanda reviewed and gave an update on the 2021 current metric scores (please see attachment: Quality Incentive Measures Update). Amanda noted the target did not change for the 2021 DHS measure and it a high benchmark. Notably the denominator is small and currently we are not meeting the measure. This said there are still outstanding claims to process and although we may not meet the measure, we anticipate a higher percentage meeting the measure than currently showing on OHA's rolling dashboard. Question arose which assessments are we struggling to meet, and it is a combination of both mental health and dental assessments, and due to the smaller than normal denominator we do not have a lot of room for failure as even one hit is significant. In addition, it has been far more challenging coordinating the FEARsome Clinic under Covid restrictions as we are still unable to pull the whole team together to see the kiddos in person.<br>• Amanda also spoke to the Immunization Combo and oral evaluation for diabetics and stated she is doubtful we will meet the benchmark for these measures as well. Regarding the new Emergency Outcome Tracking Covid-19 (EOT) measure, which OHA added later in the current measurement year, Amanda spoke to its complexity and how we are not currently meeting it. We are meeting the race and ethnicity portion of the measure, but only 25.5% of the 12–15-year old's have received their first dose with a threshold of 42% for this age group, and although we are up 16% for the 16-year-old and up age group, we are at 43.1% of a 47% threshold. We must meet all three required benchmarks for race and ethnicity as well as both age groups targets to pass. Our current strategy has been to send out monthly gap lists using ALERT data and promoting OHA focus on using PCPs to have informative conversations with members/patients to address concerns or any potential misinformation which may be a barrier to receiving vaccinations. In addition, school-based vaccination drives are also being conducted. Also of note, Amanda assured everyone although younger ages are now eligible to receive Covid vaccinations OHA will not be adding this age group to the current EOT measure, but it is still unknown if the EOT measure will be included in the 2022 incentive measure set. | |

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| Meaningful Language Access<br>• Identifying members who need interpreter services<br>• Certification scholarships (update) | • Amanda asked committee members how they identify patients/members which need interpretive services to gain insight in current practices/processes. Jamilah at CH&W stated their data base collects language preferences based on new patient and annually updated patient paperwork and ask patients in-house or at time of visit. She stated most of their patients which may need interpretive language services self-identify as Spanish speaking or Spanish as primary language, but also identify as being fluent in English. Question was asked as to how Advanced Health determines whom needs interpretive services at visits which end up on their independent chart review requests every quarter as many do not actually need interpretive services as they are fluent in English or English is their primary language. Amanda explained they will continue to fall on the quarterly Language Access Interpretive Services Chart Review request until they re-enroll and do not check the box stating they self-identify as potentially needing interpretive services. Amanda explained how important it is to identify our current work flows and process to provide interpretive services when needed, as well as how we chart services offered and/or given, as going forward this measure we will hold us accountable to provide certified interpreters and chart who provided it (who interpreted and were they certified). Sara from Bay clinic confirmed Epic has all the fields to track/ID who needs services. If they receive services, the MD's use the CPT code and include who interpreted in their chart notes. She also stated in pediatrics the kids speak English well, but their parents may not, and how when this occurs it is normally identified by the staff as they know which parents need interpretive services. Attestation process is asking how we identify who needs or does not need interpretation. Sara explained they are using sticky notes in Epic to identify parents who need services, it flags them as needing it but stated it can be tricky when offering it to a patient who may not think they need an interpreter.<br>• Mari from Adapt asked if there was a way for us to coordinate a method to "clean up" the list of members OHA is identifying as needing interpretive service, when they do not need these services, prior to full implementation of this measure. It is disconcerting as the denominator population is not accurately being identified. Some common areas of concern which incorrectly flag patients/members include a child being identified as needing services, but parents do not, such as a young child who doesn't speak any language yet, or kids which are fluent in English, but their non fluent English-speaking parents fill out OHA paperwork, which creates a "pediatric gap" when parents need it, but kids do not. Staff must be trained to identify how to schedule appropriately for patients/members requiring interpretive services and utilize in-person certified interpreters whenever able to do so. Amanda did let committee members know Advanced Health, as well as other CCO's across the state, have been pushing back often to OHA regarding the need to remove people who have been incorrectly flagged as needing language interpretive services. Also stressed the importance of using | |

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| | CPT codes as this allows for tracking and although we are not required to pay, we will support the certification of bi-lingual staff who would like to get their interpretive certification.<br>• Advanced Health will pay 100% of the cost for a qualified staff to be certified and the cost of the exam fee, however, employer will have to pay for any cost relating to the time to attend. Amanda and/or Lisa will send out the scholarship and class information as soon as it is available and ask folks to begin to identify qualified staff who might be interested. | Amanda or Lisa will send out the scholarship and interpretive certification class information once the application is finalized. |
| MEPP 2022 intervention around SUD | • Amanda spoke to the warm hand-offs occurring between PCPs and integrated pharmacist, mental health and behavioral health clinicians going on in the clinics. Data supports a lot of primary care patients/members are screened as positive for SUD, but the question asked is how we can bridge the gap from SUD to intervention? How can we use integrated specialist through warm hand offs to improve successful intervention? Amanda asked if anyone had any initial thoughts to share on this, but no one was prepared to speak to it at this time but willing to think on this and speak to it at our next meeting. | Committee members to bring their ideas on how we can bridge the gap between SUD and intervention. |
| Pharmacy PA workflow Subcommittee | • Lisa shared how Advanced Health has seen an uptick in delays in the Prior Auth (PA) process, both medical and pharmacy PAs being affected, and proposed the creation of a sub-committee of clinical community partners to work on a rapid cycle quality improvement project (note, this could be highlighted as a quality improvement project applicable towards PCPCH certification). Brandie, Advanced Health Director of Pharmacy, shared how the best way to request a PA is to include all the needed information when submitting the request. She noted pharmacy has seen an increase in PAs being submitted with missing information such as no chart notes, or the use of outdated/old notes, and/or no medication in treatment plan. She explained they have 24 hours to decide and if they must ask for additional information it slows the process down considerably, and although they can under these circumstances expand up to 72 hours if they do not receive what they need they must at that time decide and thus end up denying it. Lisa noted if we can identify why there has been an increase in PAs without required documentation and can work on improving the workflows and perhaps creating SOPs (standard operating procedures), we can greatly improve the PA approval times and decrease denials. As not enough folks in attendance to speak to the issue will revisit at a future date to discuss possibility of | Will revisit in near future when more committee members on hand to speak to the issue. |

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| | creating a subcommittee to work on improving PA processes. Of note, Jamilah stated CH&W has not seen an increase in clients/patients complaining in over a year and, as far as she knows, there have been no current PA complaints which was reassuring. | |
| 6.0 Community Partner Updates | • Jamilah shared CHW dental advanced practice hygienist integration with Behavioral Health is still on track to go live on November 10th, and case managers are excited for this service to start back up again. Noted it may take awhile to get back to where clients were asking to be seen, or showing up on dental days as walk-ins, but Jamilah believes it should not take too long once word gets out that Stephanie, the assigned advanced practice hygienist, is back. Jamilah noted she is, "fantastic." Everyone in attendance agreed the expansion of integrated advanced practice hygienists into our clinics is exciting and thrilled CH&W will have Stephanie onsite in just a few days.<br>• Question was asked if integrated dental services being offered are being tracked by CH&W and Molly at Advantage Dental stated they will be tracking the use of their services at CH&W and further confirmed they are also tracking utilization at all their integrated sites.<br>• Jamilah also stated CH&W is on track in their work to become a PCPCH home and determining what level they can attest (how many stars), and she also shared how they are working on recruiting staff, but the current housing shortage is an issue. Jamilah spoke to how difficult it has been to recruit when there is no housing available in the area. Waterfall has a condominium which is available as an Air BNB, but the housing shortage is a serious barrier. Noted this is also a serious barrier to their clients as well as part of their substance abuse goals is related to them obtaining safe housing. Jamilah shared how on top of the housing shortage, especially lack of affordable housing, people do not always want to rent to someone with mental or behavioral health issues. Although they try to place them, they often cannot. As to an example of the monetary impact due to the housing shortage, Jamilah shared currently they have 17 Aid and Assist clients and millions of dollars are used every year just on these seventeen clients, and how CH&W has been the highest in the state for years. She shared the success of the Aid and Assist apartment through Bay Area 1st Step and asked if we can get another, stating we actually need about eight of these apartments. Discussion relating to the impact of the current housing crisis in the area and need for specialized housing for Aid and Assist, low-income housing, housing for homeless, and impact of lack of housing in our community in general pursued. Agreed there is a need to act in unison, to know what everyone in our community is already doing and how we can support each other, explore ways to partner with each other, identify the gaps and how to fill the voids, and work to connect everyone to address the gaps. Jim, Chief Operating Officer at Advanced Health, stated he loved the idea for additional | |

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| | housing for the 17 Aid and Assist clients, and how important housing was to manage their care and the need to create a way for them to succeed in their goals: keeping them going forward. He spoke regarding grant specialist and partnering, community partners working together and need for purposeful grant writing and getting everyone talking.<br>• Meeting ended at 11:34 am. | |

**NEXT MEETING: December 2nd, 2021**
**Location: Plan on it being a Teams Meeting**

# Interagency Quality Committee Minutes

**October 7th, 2021**

| Attendance | | | |
|---|---|---|---|
| X | Amanda McCarthy, Quality Manager, Advanced Health | | Katy Halverson, Advanced Health Director of Behavioral Health |
| | Anna Warner, Director of Quality, Advanced Health | X | Jerry O'Sullivan, ADAPT |
| | Belle Shepherd, Innovator Agent, OHA | | Marla Smith, Compliance Officer, Advanced Health |
| | Lindsey Tyner, Quality Improvement Coordinator, NBMC | | Rosie Revelle, Office Manager, Dr. Mike & Friends |
| | Tim Novotny, Bay Cities Brokerage/Ambulance | | Dawn Gray, Chief Operating Officer, Coast Community Health |
| X | Laresa Rowden, Quality Improvement Coordinator, Bay Clinic | X | Lisa Castle, Quality Improvement Specialist, Advanced Health |
| | Leah Lorincz, Advanced Health RN Director of Member Services | | Tom Sorrells, Medical Director, Adapt |
| | Sarah Cornelison, Bay Clinic | | Debby Allen, QST, NBMC |
| X | Jamilah Mooney, Coos Health & Wellness | | Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction |
| | Devan Martin, Quality, NBMC | | Jessica Foster, QI Specialist, Coast Community Health |
| X | Mari Stout, ADAPT | | Ana Leypoldt, Coos Health and Wellness |
| | Exalena Dayley, Quality Improvement Specialist, Waterfall | | Martina Rodman, NBMC |
| X | Molly Johnson, Advantage Dental | | Geanna Berrier, Care Management, NBMC |
| | Devan Martin, Trainer, NBMC | | Alyssa Kelley, Trainer, NBMC |
| | Nina, Bay City Brokerage/Ambulance | | Karen Stafford, Southern Coos |
| | Dee Roberson, Dr. Mike & Friends | | Jane Walters, NBMC |
| | Ross Acker, Advanced Health Director of Care Coordination | | Kent Sharman MD, Chief Medical Officer, Advanced Health |
| X | Jamie Schultz, Chief Quality Administrator, Waterfall | | Lela Wells, Advanced Health |
| | Heather Garrett, Bay Clinic | | |

# Interagency Quality Committee Minutes

**October 7th, 2021**

| TOPIC | DISCUSSION / INFORMATION | ACTION REQUIRED Person Responsible |
|---|---|---|
| 1.0<br>Call to Order / Introductions | • The meeting started a bit late at 10:35 am by Lisa Castle.<br>• Roll call via Microsoft Teams/phone.<br>• Minutes from September 2021 were reviewed by all and approved at 10:38 am. | |
| 2.0<br>2021 CCO Metric Performance Update | • Amanda reviewed and gave an update on the 2021 current metric scores (please see attachment: Quality Incentive Measures Update). Amanda noted there is a lot of green but cautioned this was largely due to the change in benchmarking against 2019 performances, so our targets went down significantly and clarified the DHS measure has not yet been updated. Amanda also explained how the preventive dental for kid's measure has been decoupled (do not have to meet both to pass both), but Molly explained Advantage Dental is taking an aligned approaches to the 1-5 years and 6–14-year-old age groups. We are also meeting part 1 of the SUD measure which currently only requires us to report to pass. Primary care is now seeing younger ages which is driving the Well Care Visits for ages 3-6 up and discussed Kindergarten Readiness and how primary care plays an integral part in getting kiddos seen and warm hand offs also being done to Advantage Dental for oral care. Amanda spent some time discussing the new Covid vaccination measure (Emergency Outcome Tracking Covid-19 or EOT) and reviewed the update from OHA. We have a long way to go as we are at 40.2 % and our benchmark is 47.7%. Based on a breakdown provided by Anna we need and additional 1,251 over the age of 16 and 307 needed for 12-15 age group, as well as 7 more for Indian ethnic group and 2 more from other ethnic groups combined to meet this measure. Mari from Adapt aske if we as a CCO are doing any incentives for members to be vaccinated but there is no further conversation around additional member incentivization at this time. There are school based outreaches taking place, but the main lever is primary care where the conversations between members and their PCPs and/or pediatricians are taking place. Question asked if all members have an assigned PCP and if primary Care is truly the best lever. Can we identify who needs an additional lever? Currently we are supporting outreaches and sending member gap lists identifying members who need to be scheduled for appointments to be vaccinated. The gap lists include contact information but currently the phone numbers may need to be updated as OHA files override any updated phone number but when we go live with Quantum Choice next month, we hope to have solved this issue with a new field for updated phone numbers which will not be overridden every month. | |

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| 3.0 Collaboration with DCO and PCP offices & Update on advanced practice dental hygienists | • Molly from Advantage Dental shared exciting news that staring October 13th they began offering basic and tele-dental services at Bay Clinic. Lisa shared a success story of how a child placed into foster care and assigned to the FEARsome Clinic didn't need to have a dental assessment because of the warm hand off from his pediatrician to the Advantage Dental Expanded Practice Hygienist onsite at Bay Clinic. Lisa shared that the foster mom was really excited about it too and thought it was wonderful this service was being offered. Molly also shared Advantage Dental distribution plan to get flyers/pamphlets out, as well as how all the clinic sites currently participating can now offer both onsite and teledentistry services. Also, of note, she shared they are set up now to offer patients with a diabetic diagnosis an oral evaluation with a dentist via teledentistry. In addition, Coos Health and Wellness will resume offering onsite and teledentistry as of November 10th and North Bend Medical Center, Waterfall and Port Orford are all offering both teledentistry and onsite services. Molly will send the committee a break down of all the types of services being offered and | Molly will send a break down of all services by type currently being offered at clinic locations. |
| MEPP 2022 intervention around SUD | • Amanda brought the question to the committee members about what else they can do to move forward on S.U.D. Recommended we map where the referrals are coming and when screened for a diagnosis. Trust relationships, how do we conduct warm hand-offs, what are the referral motivations, explore various Integrated Mental Health models and address bandwidth issues. Committee identified the trust relationship developed to get patient/members to treatment. Discussed how peer support role was appropriate and how could be utilized further explored. Discussed how to assist in advancing motivation as until "painful enough" not motivated to seek treatment. Provider education critical as they do not think or understand the way a Behavioral Health/Mental Health specialist does, they do not always think to hand off to a specialist and warm hand-offs critical. Ultimately first step needs to be discovery and Mari offered to have Adapt do a presentation with providers/clinics. | Mari at Adapt offered to do a presentation for providers and clinics |
| 6.0 Community Partner Updates | No updates and meeting ended at 11:31 am. | |

**NEXT MEETING: December 2nd, 2021**
**Location: Plan on it being a Teams Meeting**

# Quality Assurance and Performance Improvement (QAPI) Policy and Procedures

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|---|---|
| Company: Advanced Health CCO | Approved by: Anna Warner<br>Title: Executive Program Director<br>Current Revision Date: March 15, 2021 |
| Department: Quality | |

## Contents:



## 1. PURPOSE

**1.1.** Advanced Health members are best served by a Quality Assurance Program designed to provide robust methods for process measurement and analysis to assure early detection of discrepancies and continual performance improvement.

## 2. SCOPE

**2.1.** Advanced Health is a Coordinated Care Organization, contracted with the Oregon Health Authority to administer the benefit for Oregon Health Plan members in Coos and Curry Counties. Advanced Health maintains a network of providers and contractors for primary physical health, behavioral health, dental health, specialty services, hospital services, chemical dependency services, and transportation services.

## 3. ACRONYMS AND DEFINITIONS

**3.1.**

## 4. POLICIES

**4.1.** Management provides evidence of its commitment to the development, implementation, and continual improvement of the Quality Assurance Program by:

- Communicating to the organization the importance of meeting member needs for effective, equitable, understandable, and respectful services, as well as statutory and regulatory requirements;
- Ensuring that member needs and expectations are determined and fulfilled in a manner that is responsive to cultural beliefs, preferred languages, health literacy, and other communication needs with the aim of improving member satisfaction;
- Planning the processes and activities needed for the Quality Assurance Program;
- Conducting an annual Quality Program Evaluation;
- Establishing an annual Transformation and Quality Strategy and Work Plan;
- Ensuring availability of resources;
- Defining organizational roles, responsibilities, and authorities; and,
- Planning actions to address risks and opportunities.

## 5. PROCEDURES

**5.1.** ***Performance Evaluation and Improvement***

Advanced Health has planned and implemented the following monitoring, measurement, and analysis activities in order to demonstrate that services provided to members conform to requirements and that the Quality Assurance Program, including the Transformation and Quality Strategy and Work Plan, performs as expected. The results of the monitoring, measurement, and analysis activities are used to improve the effectiveness of the Quality Assurance Program.

**5.2.** ***Participation as a Member of the OHA Quality and Health Outcomes Committee (QHOC)***

Advanced Health is committed to participation and attendance at the monthly Quality and Health Outcomes Committee. Advanced Health's Executive Program Director and Quality Manager regularly attend the meetings held in Salem. Other CCO employees, contractors, and providers may participate, either in-person or by phone, depending on the topic of the meeting or the learning collaborative session.

**5.3.** ***External Quality Review and Corrective Action***

Advanced Health participates in annual External Quality Reviews (EQRs) conducted by an External Quality Review Organization, as required by the Oregon Health Authority. Any findings from the EQR generate corrective action or improvement plans to eliminate the cause or causes of the problem and prevent recurrence. The corrective action or improvement plan includes a determination of the root cause, actions to address the root cause, and verification that the actions taken were effective.

**5.4.** ***Utilization Review***

A robust program of Utilization Review is in place to ensure that high quality, Medically Appropriate services are delivered to all members, including those with special health care needs. A number of mechanisms are in place to monitor for both under- and over-utilization of services.

5.4.1. *Medical Management Department Activities*

The Medical Management Department includes Utilization Review functions. This team reviews prior authorizations to ensure that treatments follow the clinical practice guidelines, the Prioritized List of Health Services and the associated guidelines to assure that services are medically appropriate and evidence-based. The list of services requiring prior authorization is reviewed at least annually for opportunities to reduce administrative burden on providers while still ensuring that care is delivered locally when possible, in a cost-effective manner, and consistent with medical evidence. The authorization process ensures that members have access to second opinions when desired, and all members (including those with special healthcare needs) may have direct access to a specialist when medically appropriate.

The Medical Services Department monitors performance to ensure that requests are handled in a timely and consistent manner. A data dashboard is in place to allow monitoring of number of authorization requests received, average and individual time to completion, percent approved or denied, and the types of requests seen. This data is used to inform staffing decisions and prior authorization requirements. Attention is focused on high risk, high dollar interventions.

### 5.5. *Grievance and Appeal System*

Advanced Health maintains a comprehensive Member Grievance System policy and procedure, including robust processes addressing Grievances, Notice of Adverse Benefit Determination, Appeals, Contested Case Hearings, requests for expedited Appeals or Expedited Contested Case Hearings, continuation of benefits, documentation requirements, and quality improvement review. Advanced Health reviews the policy and procedure annually, revising as needed to ensure the document accurately reflects the implemented process and meets all federal, state, and contract requirements. The Advanced Health policy and procedure are submitted annually to OHA for review and feedback. The Grievance and Appeal System is also part of the regular External Quality Review cycle and is reviewed at least every three years through that process.

Advanced Health works closely with organizations to which portions of the Grievance and Appeal System are delegated to ensure the processes of the delegated entities meet the requirements of the Advanced Health policy and procedure. Delegate Grievance System policies and procedures are reviewed at least annually for compliance with federal, state, CCO contract, and Advanced Health requirements. Grievance System records and data collected from delegated entities are reviewed at the time of collection and all information from delegates is incorporated into the quarterly Grievance System report submitted to OHA. The data and trends noted in the quarterly Grievance System report are also reviewed by the Interagency Quality and Accountability Committee for opportunities for system-level quality improvements.

### 5.6. *Program Evaluation & Improvement Strategy and Work Plan*

The entire Quality Assurance and Performance Improvement Program is reviewed and evaluated at least once per year to ensure its continuing suitability, adequacy, and effectiveness in satisfying the requirements of the Oregon Health Authority and Advanced Health's goals and objectives. This evaluation includes assessing opportunities for improvement and the need for changes to the Quality Assurance Program. The Quality Program Evaluation is prepared by the Executive Program Director and Quality Manager in collaboration with key subject matter experts and reviewed by the Interagency Quality and Accountability Committee, the Clinical Advisory Panel, and the CCO Board of Directors.

Input to the Quality Program Evaluation includes, but is not limited to, the following information:

- Results of External Quality Review
- Member complaints and the grievance system
- Status of current improvement efforts and suggestions for new improvement efforts
- Status of CCO quality incentive measures and other CCO performance measures

- Quality and appropriateness of care for members, especially those with special health care needs
- Improvement in an area of poor performance in care coordination for members with SPMI
- Monitoring and enforcement of consumer rights and protections
- Compliance of the fraud, waste, and abuse prevention program
- Utilization data
- Network contractor and provider monitoring results and findings

Output of the Quality Program Evaluation informs the Transformation and Quality Strategy and Work Plan for the coming year and includes decisions and actions related to:

- Improvement of the effectiveness of the Quality Assurance Program and its processes
- Improvement of member services related to requirements
- Resource needs

### 5.7. *Performance Improvement Process*

Advanced Health continually improves the effectiveness of the Quality Assurance Program through review by the Interagency Quality and Accountability Committee and other committees, participation in OHA Quality and Health Outcomes Committee meetings, participation in OHA Transformation Center technical assistance and learning collaborative opportunities, analysis of data, external quality review, and internal quality program evaluation.

OHA determines and/or approves contractual requirements for all CCOs related to Performance Improvement Projects (PIPs), Transformation and Quality Strategy components, Quality Incentive Measures, and other performance measures. Advanced Health conforms to these requirements and incorporates these improvement projects as well as other projects into its annual Transformation and Quality Strategy and Work Plan.

In managing the Transformation and Quality Strategy and Work Plan, Advanced Health employs a variety of process improvement tools, including PDSA, DMAIC, impact analysis, project management, and other lean tools. The process improvement method(s) used depend on the needs of the specific project and the capabilities of the team planning and implementing the improvements.

Process improvement priorities are determined with consideration to a variety of sources, including but not limited to:

- OHA Requirements: Performance Improvement Project focus areas, Transformation and Quality Strategy components, Quality Incentive Measures, other performance measures, and other contractual requirements
- Advanced Health's strategic plan and direction from the Board of Directors
- Community Priorities: input from the Community Advisory Councils, findings from the Community Health Assessments, and priorities identified in the Community Health Improvement Plans
- External Quality Review results
- Member complaints and grievance reports
- Cultural and linguistic needs of Advanced Health members
- Delegate and provider compliance
- Delegate, provider, and community partner feedback
- Annual Quality Program Evaluation
- Other statutory and regulatory requirements

### 5.8. *Committees*

Advanced Health's Quality Assurance and Performance Improvement processes rely on a series of collaborative, yet distinct and well-defined standing committees. Each committee is characterized by a charter that defines the committee's purpose, goals, schedule of meetings, scopes of authority, membership composition, and member responsibilities. The standing committees that participate in Quality Assurance and Performance Improvement processes are described below.

### 5.8.1. *Interagency Quality and Accountability Committee*

This committee is chaired by the Advanced Health Director of Quality and attended by representatives of delegate organizations, as well as community partners and providers. The Interagency Committee meets monthly. The purpose of this committee is to provide a platform for collaboration and coordination between Advanced Health's leadership, contractors, network provider organizations, and community partners purposed at achieving the Triple Aim. This committee supports data-driven decision making and development of a culture of quality through the review of data reports that support OHA contract compliance, achievement of Advanced Health's strategic plan, advances in individual and population health, enhancement of the member's experience of care, and cost efficacy. The Interagency Quality and Accountability Committee reports to the Advanced Health Board of Directors.

### 5.8.2. *Clinical Advisory Panel*

The Clinical Advisory Panel is chaired by Advanced Health's Chief Medical Officer and membership includes providers representative of behavioral health, physical health, dental health, and substance use treatment. The CAP usually meets twice per month. The CAP provides input on clinical programs and policies with the goal of achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy. The Clinical Advisory Committee provides perspective of practicing clinicians to Advanced Health. The Clinical Advisory Panel reports to the Advanced Health Board of Directors.

### 5.8.3. *Pharmacy and Therapeutics Committee*

The Pharmacy and Therapeutics Committee meets at least quarterly. Committee membership includes Advanced Health providers representing various specialties (e.g. family practice, internal medicine, OB/GYN, pediatrics, mental health etc.) and may also include community partners (e.g. Bay Area Hospital) and pharmacists. The Pharmacy and Therapeutics Committee is responsible for maintaining a formulary providing the most cost-effective drug therapies to Advanced Health members and ensuring compliance with DMAP rules and regulations. The Pharmacy and Therapeutics Committee reports to the Advanced Health Clinical Advisory Panel.

### 5.8.4. *Community Advisory Councils*

Advanced Health has established two Community Advisory Councils, one in Coos County and one in Curry County. Both councils hold monthly meetings. Membership includes a broad spectrum of representatives, including Advanced Health members and their families, health providers, non-clinical partner organizations, and other key community representation. Over 50% of the councils are consumer representatives. The purpose of these councils is to provide the voice of the consumer to advise Advanced Health and its governing body in its efforts to meet the Triple Aim of better health, better care, and lower costs. The Consumer Advisory Councils report to the Advanced Health Board of Directors.

### 5.8.5. *Community Health Improvement Plan Committees*

The Consumer Advisory Council (CAC) provided input and recommendations on priorities of the Community Health Improvement Plan (CHIP). The Coos and Curry CHIP Steering Committees are responsible to set up appropriate supports and structures to monitor and move the work of the CHIP forward. Each CHIP subcommittee is responsible to develop an implementation plan for achieving the goals and objectives outlined by the CHIP. Progress reports are presented for approval to the respective CAC and then to the Advanced Health Board of Directors.

### 5.9. *Transformation and Quality Strategy (TQS) Development Process*

Much of the process for the TQS analysis, development, and planning is described in the above sections regarding the Program Evaluation & Improvement Strategy and Work Plan and the Performance Improvement Process. The Executive Program Director and Quality Manager worked with the key personnel and committees described above beginning in the third quarter of the calendar through January of the reporting year to select the list of projects and programs to be included in the TQS to highlight the work of Advanced Health and that best address the required TQS components. These projects and programs include priorities that align with the Community Health Improvement Plan, CCO quality measures, PCPCH standards, CPC+ program metrics, contract requirements, current and future Performance Improvement Projects, as well as other statutory and regulatory requirements.

The TQS projects and programs are presented for discussion and feedback, beginning in the fourth quarter of the year prior to the reporting year, to the Interagency Quality and Accountability Committee and the Clinical Advisory Panel. The Consumer Advisory Councils work on the Community Health Improvement Plan throughout the year, and that information is incorporated in the presentations to the other committees. The information is presented to the Advanced Health Board of Directors for review and approval prior to the March submission to OHA.

In February and March of the reporting year, additional details, data, activities, and targets are collected from the project or program leaders. Final versions of sections are reviewed by relevant executive leadership and other personnel involved as needed, including those functions discussed below in the Organizational Roles and Responsibilities section.

## 6. REFERENCE SOURCES

**6.1.** §438.330 Quality assessment and performance improvement program

**6.2.** Exhibit B – Statement of Work: Part 10 Transformation Reporting, Performance Measures and External Quality Review

## 7. RESPONSIBILITES (Compliance, Monitoring, Review)

### 7.1. *Executive Program Director*

The Executive Program Director has the authority and responsibility to make appropriate changes to the Quality Assurance Program and to communicate the requirements to personnel. Every level of management shares the responsibility to ensure proper maintenance and performance of the Quality Assurance Program. A brief overview of key titles and their responsibilities related to the quality assurance program is provided below.

### 7.2. *Board of Directors*

- Representative of equity partners, community partners, community stakeholders, and the Community Advisory Councils

- Guides, controls, and directs the organization through the adoption and review of annual strategic plans, the annual budgeting process, and written policies
- Oversees the performance of the organization
- Reviews and authorizes the annual Transformation and Quality Strategy
- Ultimately responsible for the quality of clinical services provided to members

**7.3.** ***Chief Executive Officer***

- Facilitates business planning and develops appropriate strategies to attain annual strategic objectives
- Reviews activity reports and financial statements to determine progress and status in attaining quality, performance, and compliance objectives
- Ensures adequate resource availability
- Ensures the promotion and awareness of member needs and contract requirements throughout the organization
- Reports directly to the Board of Directors

**7.4.** ***Chief Compliance Officer***

- Ensures contractual obligations as well as statutory and regulatory requirements are met
- Oversees the development, review, and revision of the compliance plan
- Implements the compliance plan
- Audits and monitors contractors and providers
- Opens and performs preliminary investigations regarding Waste, Fraud, and Abuse and makes referrals to OPAR or MFCU as required

**7.5.** ***Chief Medical Officer***

- Ensures services are medically appropriate, high quality, cost-effective, and in accordance with Oregon Health Authority (OHA) Coordinated Care Organization (CCO) contract and related Oregon Administrative Rules (OAR) and the Code of Federal Regulations (CFR)
- Reviews member Appeal and Contested Case Hearings requests
- Ensures assigned staff adhere to medical policy and member benefits

**7.6.** ***Executive Program Director***

- Directs development, implementation, and improvement of the Quality Assurance and Performance Improvement Program and annual Transformation and Quality Strategy
- Develops, implements, and communicates quality improvement strategies throughout the organization as well as to delegate and provider network, community partners, and other stakeholders
- Assists with the annual External Quality Review process
- Oversees Member Grievance System
- Health Equity Administrator

**7.7.** ***Directors and Managers***

- Oversee successful operation of assigned area of responsibility to ensure production efficiency, quality of service, and cost-effective management of resources
- Coordinate business practices and procedures to optimize operations
- Ensure training of new and existing employees
- Support efforts to improve the effectiveness of the Quality Assurance Program
- Provide direction to staff
- Assist with annual EQR process in areas of assigned responsibility

## 8. RELATED DOCUMENTS

**8.1.** Interagency Quality Committee Charter

**8.2.** Clinical Advisory Panel Charter

**8.3.** Pharmacy and Therapeutics Committee Charter

**8.4.** Coos and Curry Community Advisory Council Charters
**8.5.** Coos and Curry Community Health Improvement Plans
**8.6.** Coos and Curry Community Health Assessment
**8.7.** Annual Transformation and Quality Strategy

## 9. ATTACHMENTS

**9.1.** None

## 10. APPROVALS

**10.1.** Document Owner

10.1.1. __Anna Warner, Executive Program Director_____

**10.2.** Collaborators

10.2.1. __Amarissa Wooden, Quality Manager_____

**10.3.** Approvals

10.3.1. Committees

10.3.1.1. _N/A_____

10.3.2. Signers

10.3.2.1. __Anna Warner, Executive Program Director____

Signature: _____

**10.4.** Original Effective Date _____

10.4.1. __July 29,2015_____

**10.5.** Revision Date

10.5.1. __March 12, 2020_____

10.5.2 __March 15, 2021_____

**10.6.** Review Date

10.6.1. _____

# Interagency Quality Committee Minutes

**September 2nd, 2021**

| Attendance | | | |
|---|---|---|---|
| X | Amanda McCarthy, Quality Manager, Advanced Health | | Katy Halverson, Advanced Health Director of Behavioral Health |
| | Anna Warner, Director of Quality, Advanced Health | X | Jerry O'Sullivan, ADAPT |
| | Belle Shepherd, Innovator Agent, OHA | | Marla Smith, Compliance Officer, Advanced Health |
| | Lindsey Tyner, Quality Improvement Coordinator, NBMC | | Rosie Revelle, Office Manager, Dr. Mike & Friends |
| | Tim Novotny, Bay Cities Brokerage/Ambulance | | Dawn Gray, Chief Operating Officer, Coast Community Health |
| X | Laresa Rowden, Quality Improvement Coordinator, Bay Clinic | X | Lisa Castle, Quality Improvement Specialist, Advanced Health |
| | Leah Lorincz, Advanced Health RN Director of Member Services | | Tom Sorrells, Medical Director, Adapt |
| | Sarah Cornelison, Bay Clinic | | Debby Allen, QST, NBMC |
| X | Jamilah Mooney, Coos Health & Wellness | | Tami Graziano, Coquille Valley Hospital Manager Quality/Risk/Patient Satisfaction |
| | Devan Martin, Quality, NBMC | X | Jessica Foster, QI Specialist, Coast Community Health |
| X | Mari Stout, ADAPT | | Ana Leypoldt, Coos Health and Wellness |
| | Exalena Dayley, Quality Improvement Specialist, Waterfall | | Martina Rodman, NBMC |
| | Molly Johnson, Advantage Dental | | Geanna Berrier, Care Management, NBMC |
| | Devan Martin, Trainer, NBMC | | Alyssa Kelley, Trainer, NBMC |
| | Nina, Bay City Brokerage/Ambulance | | Karen Stafford, Southern Coos |
| | Dee Roberson, Dr. Mike & Friends | | Jane Walters, NBMC |
| | Ross Acker, Advanced Health Director of Care Coordination | | Kent Sharman MD, Chief Medical Officer, Advanced Health |
| | Jamie Schultz, Chief Quality Administrator, Waterfall | | Lela Wells, Advanced Health |
| | Heather Garrett, Bay Clinic | | |

# Interagency Quality Committee Minutes

**September 2nd, 2021**

| TOPIC | DISCUSSION / INFORMATION | ACTION REQUIRED Person Responsible |
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| 1.0<br>Call to Order / Introductions | • The meeting started a bit late at 10:35 am by Lisa Castle.<br>• Roll call via Microsoft Teams/phone.<br>• Minutes from August 2021 were reviewed by all and approved at 10:39 am. | |
| 2.0<br>2021 CCO Metric Performance Update | • Amanda reviewed and gave an update on the 2021 current metric scores (please see attachment: Quality Incentive Measures Update) and discussed current data issues impacting MedInsight implementation. MedInsight implementation team working on resolving the data issues but anticipate it will now be sometime in October before we have these issues resolved. Of note, MedInsight portal is officially in production mode and when completed will allow for not only clinic/vendor level data but provider specific data on all the measures. Amanda will give another update when we next meet and hopefully we will be able to give access to stakeholder representatives sometime next month.<br>• Amanda also spoke to the glide pathway to full implementation of the new Equity: Meaningful Language Access Measure which we have all determined will be quite challenging. Although currently this measure is report only, and 2022 will be a reporting only year for sampled review, starting in 2023 OHA will be setting a benchmark and CCO specific improvement targets for a percentage of interpreter services provided by certified or qualified interpreters. Everyone expressed a thankfulness to have another year until full implementation. Based on the quarterly Language Access chart reviews results so far, we have much work to do to be ready for 2023.<br>• Mari from Adapt noted HEDIS made updates a month ago and questioned if this impacts the measures. Amanda clarified OHA Metric & Scoring Committee will not make any changes to a measure mid-year, but any HEDIS updates would be reflected in upcoming measure specification data sheets. | |
| 3.0<br>LEAN Kaizen Event Update | • Amanda updated the team that we had cancelled the LEAN Kaizen training due to pandemic and the inability to have it in person. Discussed whether to schedule it as a virtual training and everyone confirmed again, they would prefer to wait and schedule when we can have it in person. We will send out a vote button to participants regarding their future availability once we are past the current up-tick in community Covid cases. Concern as to the health and safety of patients/members due to current Covid up-tick in our communities, | Will revisit after the New Year. |

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| | capacity issues and further possible impact on already short staffing ratios due to governor's mandate and providers and staff still learning Epic at larger clinics. Noted there is just too much on everyone's plates right now to engage in LEAN Kaizen training event even if we could hold it in person. | |
| 5.0 Community Partner updates | • Mari shared Adapt was now 4 months post go-live with Epic and now in stabilization stage. Also shared the fantastic news of the grand opening of Adept's new sobering center in Douglas County and how Jerry Sullivan is now in the new role as the Chief of Regional Business. Congratulations Jerry! The new sobering center creates a place for folks to safely sober up, keeping them out of the hospital, and directly connects them to community resources and is also a critical alternative to jail. Medical services are not offered onsite, no clinical treatment is offered, so this model does not require clinical staff which helps to keep the cost down. Mari explained it took 2 years of planning and committed community support, as currently there is no way to bill for their services, thus they are relying solely on alternative funding sources. Jerry worked hard on its implementation and is a great resource for additional information, and we have included links to some news articles for more information below (thank you Mari!):<br><br>Sobering center in Roseburg finally opens \| Court \| nrtoday.com<br><br>Adapt Opens Sobering Center in Roseburg – Adapt Oregon<br><br>ADAPT OPENS SOBERING CENTER IN ROSEBURG - KQEN News Radio<br><br>• Jessica from Coast Community shared they have started Covid vaccine events again once a week @ 1 pm but noted there is a 6 to 8 month wait from initial vaccinations for folks identifying a need for a booster.<br>• Jamie at CHW shared they are currently inundated with patient with mental health needs. CHW had two therapists pass away recently and currently it is taking 3-4 weeks to get initial assessments. Notably, clients are getting more anxious and more fearful, and working hard to keep up and get fully staffed. In addition, there is no accessible or affordable housing which complicates both recruiting for new staff as well as homelessness issues within our community.<br>• Jessica from Coast Community also noted increase in social health needs, food security issues, noted increase in prescriptions/medications & food boxes going out to improve access; conducting ding and dash drop offs.<br>• Everyone confirmed they are feeling stretched due to the impact of current pandemic conditions within our local communities. | |

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| 6.0<br>Adjourn | Meeting adjourned early at 11:23 am. | |

**NEXT MEETING: October 7th, 2021**
**Location: Plan on it being a Teams Meeting**