Section 1: Transformation and Quality Program Details

A. **Project short title**: **Engage Partners to Improve the Quantity and Quality of Housing Options for Individuals Experiencing SPMI**

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

If continued, insert unique project ID from OHA: **173**

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Serious and persistent mental illness
iii. Component 3 (if applicable): Social determinants of health & equity
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.

COVID 19 created complications for all key activity interventions associated with this project due to the necessary shift in activities and resources. YCCO and community partners' focus moved to the ability to get behavioral health services and supports to Members despite the pandemic. YCCO's engagement with Yamhill County Health and Human Services (YCHHS) included working closely together to identify behavioral health and support needs, including housing, for both Medicaid and non-Medicaid individuals. Identified needs included hotel rooms for homeless Members needing to quarantine, access to food, and transportation beyond treatment appointments. The YCCO Board of Directors allocated COVID funds for community partner projects, provider stabilization, and NEMT. Support for housing related investment included over $300,000 for Yamhill Community Action Partnership (YCAP) for rental assistance, energy assistance, etc. and the local Service Integration Team (SIT) Team.

The Sheridan housing development project was originally scheduled to break ground in Spring of 2020. Due to COVID 19 and other complications the timeline was changed to February 2021. Framing of the first half of the units is scheduled for the first part of March 2021, with an estimated completion date of June for the initial units. YCHHS has created the draft job description for the onsite peer support who will be responsible for coordinating pro-social community activities, and recovery supports as well as providing 1:1 support as needed to the residents.

Housing resource assessment included coordination with YCHHS to outline all current housing support options that focus on individuals with behavioral health, including SPMI, challenges. Section D below provides additional information for this key activity. Data sharing activities have included increased data provision from YCHHS to YCCO and YCCO hiring of a consultant to explore implementation of a Community Information Exchange (CIE). When implemented the CIE will enable stakeholders to connect health and social care for Members.

While progress was inhibited in 2020, local supported housing solutions have increased from 37 slots in 2012 to 85 in 2019. In 2021, Phase I of a new 65 unit supported and recovery housing program is targeted to open in Sheridan, with 32 units the first year dedicated to providing permanent housing for people coming out of SUD services, who may have co-occurring SPMI. Sheridan has been identified as a key population center for service expansion as it serves the West Valley with historically less access to services.

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

As part of the YCCO Comprehensive Behavioral Health Plan – Progress Report an assessment of current housing resources available for individuals with behavioral health challenges was conducted. The following resources were identified: **Aspen Ridge**: 15-unit complex and wellness program providing long term housing for individual with significant co-occurring mental health and physical health/medical challenges. A Peer Support Housing Specialist residing on-site, in conjunction with the residential team, provide daily on-site support and skills training. **Sunnyside**: 15-unit clean and sober living complex providing long term housing for individuals with mental illness who require ongoing support with independent living tasks. Daily onsite support is provided based on individual needs. **Homeport**: 14-unit complex providing long term housing for individuals with mental illness who require ongoing support with independent living tasks. Daily onsite support is provided based on individual needs. **Baker Field Transitional Apartments**: 7-unit complex providing transitional housing for individuals with mental illness who require support/skills training to be successful with independent living. Length of stay is 6-8 months (12 months max). A Peer Housing Specialist resides on-site, in conjunction with residential team, provides daily on-site support/skills training as needed. Residents work with a Housing Coordinator to find long term housing. **Transitional Treatment Recovery Services (TTRS):** 4 houses designed to provide safe and sober housing along with intensive alcohol and drug treatment and family stabilization services in a structured, supervised environment for parents and their children. **Peer Assisted Crisis (PAC) House** offers 24-hour support in a voluntary setting for individuals experiencing psychiatric crisis. PAC offers a comfortable, non-institutional, and recovery-focused environment to support individuals with achieving psychiatric stabilization within the community as an alternative to the emergency department, acute care, or jail. The program is also intended for individuals stepping down from acute care or state hospitalization who require additional support for a successful transition back to the community. Care Managers focus on connecting Members with a provider appropriate to their needs and preferences.

<u>Housing Overview:</u>

Housing Resource	# Units	Population of Focus	Duration
Aspen Ridge	15	Co-occurring MH & Medical	Long term
Sunnyside	15	Clean & sober living for individuals with MH	Long term
Homeport	14	MH	Long term
Baker Field Transitional Apartments	7	MH	Transitional
Transitional Treatment Recovery Services	4 Houses	SUD (co-occurring MH generally present)	Transitional
Peer Assisted Crisis (PAC) House	1 Facility: Up to 6 individuals	MH Crisis or hospital step down	Limited Duration

E. **Brief narrative description**:

YCCO, in collaboration with the LMHA/CMHP (YCHHS), has a longstanding history of partnering with the Housing Authority of Yamhill County (HAYC) to support individuals with SPMI. YCCO's contract with YCHHS prioritizes methodology that supports this and other collaborations and supports that are critical for SPMI Members. The current model includes prioritization of SPMI client referrals for specific properties and provides Section 8 for eligible individuals. YCHHS provides intensive community-based supports for individuals to help them stabilize, develop skills, and maintain or move on to more permanent housing. HAYC has prioritized Section 8 Fast Track Vouchers for YCHHS SPMI clients, allowing more rapid access than standard Section 8 vouchers. YCCO will engage with Yamhill County Health and Human Services and other community partners to evaluate the current housing options and placements for members who have a diagnosis of SPMI and comorbid Substance Use Disorders. There are many levels of care that are available in the community for this population, but there is opportunity to help better engage these members in their physical health care while they are living in these supported environments. Key activity interventions will include ongoing support for the Sheridan project in order to ensure the addition of 65 new units to the Yamhill region and increased participation in community driven housing efforts. This community voice prioritized process will inform the YCCO SDoH Spending Plan and strategic investments in housing supports and guide improvements in service delivery and efficacy.

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

Activity 1 description (continue repeating until all activities included): YCCO will perform a resource assessment of the community, creating a brief inventory of current housing resource that may be available for members, especially those experiencing SPMI or substance use. Data collection will include meetings with community organizations, surveys, scanning current community needs assessments, email outreach, and other methods as needed.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: YCCO will assess current inventory of housing opportunities, options, and supports available to its members. YCCO will increase the level of information and data available to support assessment of housing resources.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
12 known stabilization and supportive housing units with one in the process of development	All housing programs in the YCCO service area identified	4/2021	100% of housing programs in the YCCO service area are identified and information regarding the programs are compiled in a single resource document	11//2021

Minimal collaboration with housing related entities, including Community Based Organizations	Regular collaboration between YCCO and housing-related entities, including CBOs;	6/2021	YCCO will actively participate in the community chosen Built to Zero housing collaboration efforts.	12//2021

Activity 2 description: YCCO will work with YCHHS to improve data flow from housing support programs. YCCO will review housing resource assessment, utilizing its Community Advisory Council to recommend strategic funding or partnership strategies. YCHHS will provide data, utilizing their EHR, to YCCO regarding member(s) in the supported housing situations so that the physical healthcare needs of the members can be addressed, when appropriate. Care plans for these individuals will be shared regularly and at regular Multi-Disciplinary Team (MDT) meetings so that care can be fully coordinated.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: YCCO will improve workflows between HHS housing staff/programs and YCCO care management and MDT staff. YCCO will work with its Community Advisory Council to produce a recommendations s based on the resource assessment, using an equity lens, member data, and the current CHIP to guide the decision-making process.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current indication of whether members receive housing supports from HHS	HHS establishes housing supports indicator in reports to YCCO	6/2021	90% of YCCO member data received from HHS includes housing information	12/2021
Housing program data has not been collected in a consistent manner	Housing data will be gathered and used in the Comprehensive Behavioral Health Plan process	6/2021	CAC and QCAP will review housing data and make recommendations	11/2021

A. Project short title: **Oversight & Monitoring Member Language Accessibility**

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

If continued, insert unique project ID from OHA: **174**

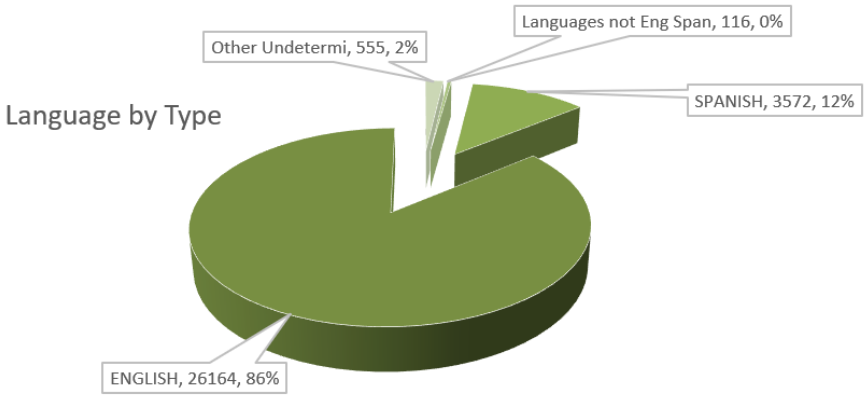
B. **Components addressed**

i. Component 1: CLAS standards
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? 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

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

In 2018 and 2019 work with CLAS Standard 11 developed demographic dashboards and an analytic framework that reflects the use of REALD demographic categorical analysis. These reporting structures and guide are now used for audit and oversight of YCCO internal operations and plan partners when doing program analysis. Demographic information generated from the Community Health Assessment is also reviewed by the Committee to inform and identify focused areas of improvement. These data also informed the development of the Health Equity Plan focus areas for ensuring culturally and linguistically appropriate services are available for member with limited English proficiency or who are deaf and hard of hearing. Survey results from providers revealed there is improvement needed in understanding language accessibility requirements and additional workflows to oversee the quality and competency of language assistance provided.

Demographic data for Language represents approximately 12% of members who report Spanish as their primary spoken language and less than 2.5% speak languages other than English or Spanish or chose not to identify.



Based on language access data collected and reported in 2020, approximately 44% (1612 unique members) who identify as speaking a language other than English received interpretation services from a qualified/certified interpretation source. With the overlay of provider accessibility survey data, it is also believed that additional language services are being offered through providers direct or through office staff

and are not being captured or reported. It is unknown if these language supports meet the standards of qualified or certified language services. Further data collection strategies to capture all language services is a long-term goal.

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

CCOs are required under Federal and State rules to provide culturally and linguistically appropriate services to members at no charge. While these requirements are written and implemented in a variety of policies, procedures, handbooks and contractual agreements, the quality and consistency of the delivery of these services is partially unknown. Grievance and customer service data does not indicate significant reported barriers in these areas.

As a continuation of project work from the past year assessments and activities, data specific to the utilization and quality of language services is available at the plan level and some pockets of language services utilized at the provider level. The first year of this cycle developed demographic dashboards to easily assess all REALD demographic composition and then use these data by applying quality, access, utilization and care composition analysis using other administrative data. The use of REALD demographic data applied to business assessments is now a standard procedure when initiating any analytic study (CLAS Standard 11).

A comprehensive understanding of the quality and consistency of language services delivered at the provider level is more difficult to measure and evaluate. Previous project activities focused on updating policies and procedures and requesting language access data from partners and providers monitoring and oversight. The learnings from the language access reporting are that quality language services are provided to members through a variety of modes, direct provider language services data/interpretation is limited. To address this, a language accessibility survey was piloted the latter part of 2020 to understand provider capabilities in offering assistive service, staff training and protocols, and established policies and procedures. A copy of the accessibility survey (Accessibility Survey 2020) is attached for reference and will be used as baseline for continued collection and assessment in 2021. TQS project 3 focused on assessing member communication from the provider network through various modes (appointing, after visit summaries, member education materials) is being abandoned and provider assessment worked into this project. See Project 3 closeout for specific details on why this project was unsuccessful and resources allocated to this project effort. Previous activities were successful in that YCCO quickly learned that more data infrastructure and technical assistance is needed before reaching its goals.

E. **Brief narrative description**:

This transformation project will be a continuation of activities to deepen the oversight and monitoring of the provider networks ability to provide culturally and linguistically appropriate services. Assess within the provider network utilization of language services not captured through daily operational practices, the ease and accessibility of accessing languages services for members, and the oversight practices ensuring quality of language services. Additional development to support a provider network that is equipped to identify and offer language appropriate services and supports to members is targeted using the following strategies:

- Continue conducting both provider and member needs assessment with a focus on the provider delivery system processes and procedures (CLAS Standard 10). Use established accessibility survey,

member health screening forms and post-service surveys to gather this date along with other member facing committees such as the Community Advisory Council (CAC).

- Use needs assessment information to inform a provider tools kit that is a partner guide to organizational policies and procedures surrounding the requirements to offer culturally and linguistically appropriate services (CLAS Standard 13). This guide will address topics of compliance, staff training, definition of and procedures for accessing certified/qualified interpreters, and accessible member materials and translation.
- Deliver a variety of training and technical assistance supports to providers to educate and reinforce language access requirements and available tools to ensure members who seek care receive culturally and linguistically appropriate within YCCO programs and services (CLAS Standard 4).

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

Activity 1 description: Continue fielding provider survey to learn how language services are requested, acquired, documented/tracked and assess for quality. Integrate these collection tools into ongoing network monitoring and oversight (CLAS Standard 10).

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Provider survey response rate

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Provider survey developed and piloted with 15 PCPCH providers with 73% response rate. (11/15)	100% response rate from PCPCH providers 60% response rate from provider network in whole	12/31/2021	Add text here.	Add text here.

Activity 2 description: Produce and pilot a toolkit to assist providers in developing language access workflows, data capture systems and quality assurance procedures and practices (CLAS Standard 13).

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Provider survey results inform toolkit components

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current support tool exists	Toolkit developed	08/2021	Toolkit updated with feedback from pilot	10/2021

Monitoring activity 2 for improvement: Toolkit piloted with PCPCH providers (original population who took the provider survey in 2020 activities)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current support tool exists	Pilot tool kit with PCP providers	09/2021	Toolkit integrated into standard provider resources shared upon contracting	12/2021

Activity 3 description: Through various forms of communication with the provider network, increase awareness and compliance with requirements to offer culturally and linguistically appropriate services; increase use of demographic data and workflows to identify language access needs of members; and reinforce language access reporting requirements.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Provider communication, technical assistance (TA) and training

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Current TA is offered six (6) times per year with two (2) site visits annually.	Two (2) additional trainings/technical assistance opportunities offered with language accessibility focus	12/2021	Language accessibility trainings an integrated part of provider training offered.	Ongoing

Monitoring activity 1 for improvement: Language access reporting received from providers

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No requirements for providers to report Language Access data	Providers report quarterly language access data with EHR data reporting for other eCQM (electronic clinical quality measures)	06/2021	Language Access reporting is part of standard reporting from providers	Ongoing

Monitoring activity 1 for improvement: Updates to provider-specific documents and materials (policies and procedures, provider handbook, contract language, workflow job aids for accessing customer service and language service providers)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Policies and procedures updated. Other documents not reviewed.	All provider facing documents and materials are reviewed and updated to ensure comprehensive reference to language access requirements	12/31/2021	Annual review and update	Ongoing

A. Project short title: **Integration of PCPCH and Oral Health**

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

If continued, insert unique project ID from OHA: **176**

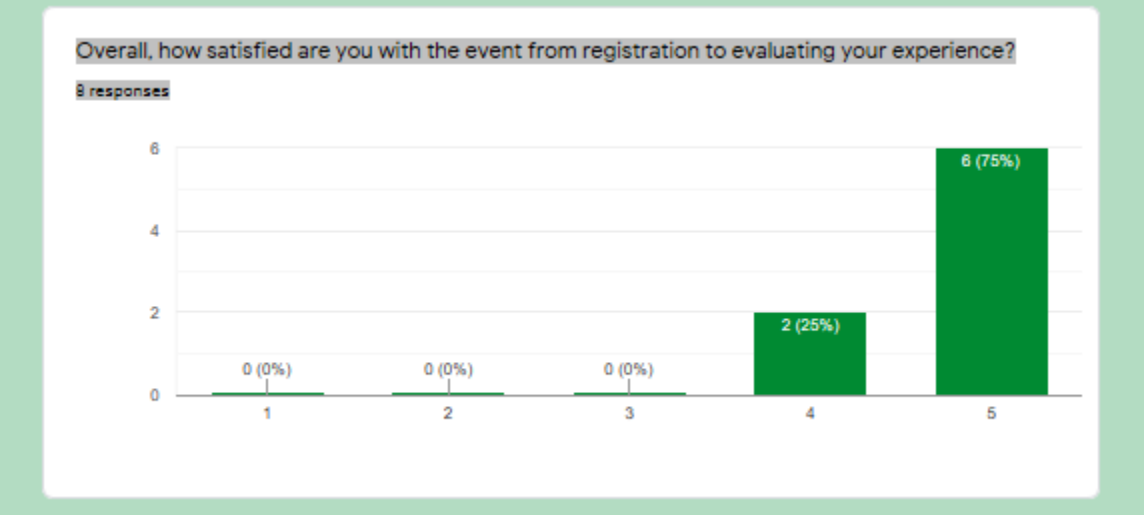
B. **Components addressed**

i. Component 1: Oral health integration
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.

YCCO has gathered and analyzed the following information to assess this component:

- Community feedback from YCCO and local committees and coalitions (ELC, OHC, QCAP)
- Member engagement data
- Community feedback from CME Meet and Greet event, follow up stakeholder interviews.
- Results from CME Meet and Greet event (attendance, sectors represented, topics covered)
- Surveys from event
- Follow up from OHC and QCAP.
- 100% of attendees indicated they learned something from the event that they would implement in their practice.
- Overall satisfaction with CME event was good.



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

In healthcare there have previously been silos created between physical health, behavioral health, and dental communities. One of the focus areas among CCOs over the past several years to has been to create a model that supports more integrated care, to provide more whole person healthcare. This is especially important in disparate and rural populations who struggle to access even the most basic healthcare. YCCO is committed to move this work forward by getting different types of providers in the same room to start the conversations about how to best integrate care in the community and build stronger wraparound care networks and referral pathways. More integrated care coordination in Primary Care Clinics will allow clinics to continue on a path to provide more Patient Centered Primary care. Creating pathways for care coordination in behavioral health and dental allows those providers to provide more whole person care as well. In this space providers can discuss topics that affect all areas of medicine and decide how the community can best work together. Many healthcare issues touch physical, behavioral, and dental providers alike, so there is a need to learn to work together to achieve better patient outcomes. YCCO has hosted two meet-and-greet events, targeting network building between behavioral health, oral health, and primary care providers, and will be expanding this method to oral health, behavioral health, specialty, and primary care. A Meet and Greet activity was held in December and there were 43 providers in attendance. The next event is scheduled for June to continue the conversation and evaluate the progress that has been made.

E. **Brief narrative description**:

YCCO hosted a meet and greet event that included providers from physical, dental, and behavioral health to help build relationships and share about best ways to work together. This event was held on the evening of 12/02/2020. The two goals were to build both interdisciplinary relationships and referral pathways, as well as offer relevant educational topics like tobacco cessation and diabetic care. CME was offered to physical, dental, and behavioral health providers to encourage attendance to this meet and greet activity. To guide this work, YCCO convened the local Oral Health Coalition to act as the group's steering committee for the event.

The biggest next step in 2021 in the next meet and greet activity in June. Between now and then 5 clinics have been identified who indicated that they don't know how to refer across systems and provide some one on one

TA. Another goal is to update referral documents and get them into a centralized space or format so that they are easily accessible to all providers.

During the last CME event, the Integration Specialist from Capitol Dental discussed different integration models. YCCO was also lucky to have a hygienist who is working in a local primary care clinic to talk about her experience, as well as the medical staff from that clinic to talk about implementation and the benefits the hygienist has added to their practice.

YCCO is also committed to provide access to system partners at Providence, Capitol and Yamhill County Health and Human Services, such as Community Integration Manager (CIM) and The Collective Platform, in order to share information about members they are serving. Continued efforts in 2021 need to be made to further educate the provider network on the use of these tools.

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

Activity 1 description (continue repeating until all activities included): Targeted technical support based on results from 2020 Meet and Greet event

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: YCCO will connect with local clinics that identified barriers to integration, gathering and sharing best practices for strengthening referral pathways, understanding interdisciplinary support, and increase engagement.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
YCCO Operations meetings with subcontractors are specific to each discipline	Oral health representative integrated into regular BH Ops meeting; BH Rep at OH Ops meeting	5/2021	More practices will understand how to use tools such as The Collective Platform and CIM to share information about members. Also, enhanced communication among care coordinators across systems.	12/2021
First event completed	Resources and workflows compiled and sent to event attendees	2/2021	Event attendees utilize resources and increase connections	12/2021
3 clinics identified that experience barriers	5 targeted TA sessions held with three clinics that	12/31/2021	Information sharing between	12/2021

	identified barriers during event		disciplines increased	

Activity 2 description: Hold one oral health focused CME event for all providers; hold one trauma-informed care focused event for all providers.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Events completed and evaluated.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 Meet and Greet event held	2 CME events held and evaluated	First Event Held 12/02/2020. Second event scheduled for 6/26/2021.	At least annual events that cross disciplines to continue and refine this work.	12/31/2022

A. **Project short title**: **Behavioral Health Neighborhood**

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

If continued, insert unique project ID from OHA: **177**

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Serious and persistent mental illness
iii. Component 3 (if applicable): Special health care needs
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.

Despite the challenges each Behavioral Health Neighborhood (BHN) clinic faced due to the COVID-19 pandemic in 2020 both continued to engage with their specific cohort of members (SPMI diagnosis). Although in person visits saw a 77% decrease, both clinics were still able to connect with many of their assigned members through telemedicine appointments to ensure continued primary care engagement. However, due to these in-person visit limitations, specific clinical quality measurements were far more difficult to collect and track. Since many of these identified members have more than one physical health comorbidity (diabetes, hypertension, etc.) it makes continued engagement with a primary care physician even more critical.

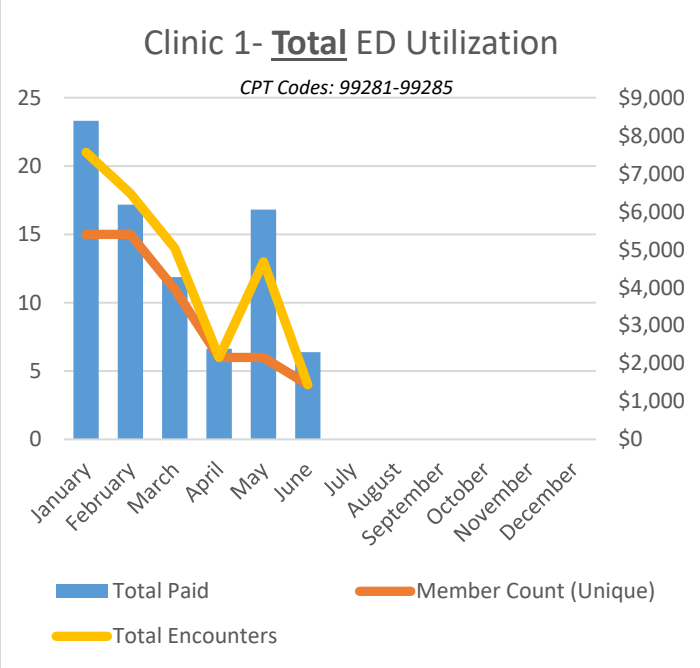
Along with the other data collected, clinics have begun to enter care plans on all members who have been identified in the program into The Collective Platform. Clinics are also creating cohorts of members within the

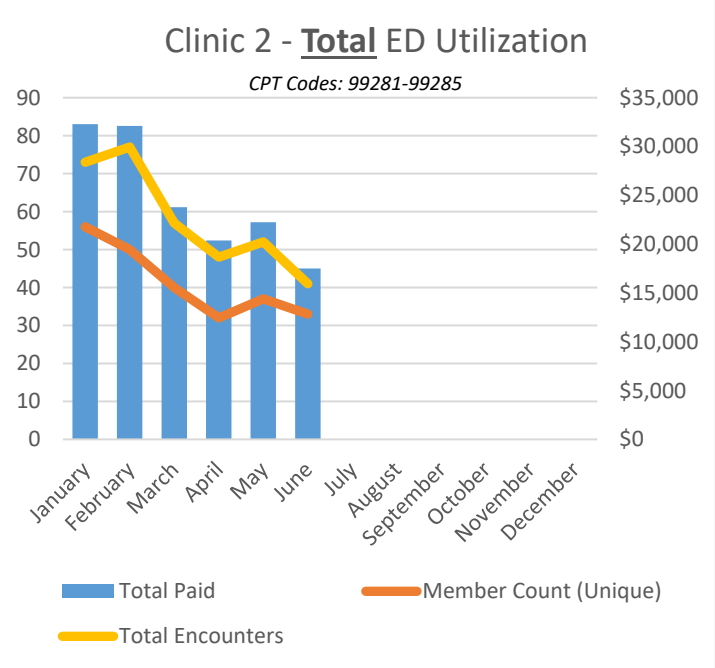
platform to identify when this population goes to the ED. YCCO will initiate monitoring processes of this data for both clinics beginning in 2021.

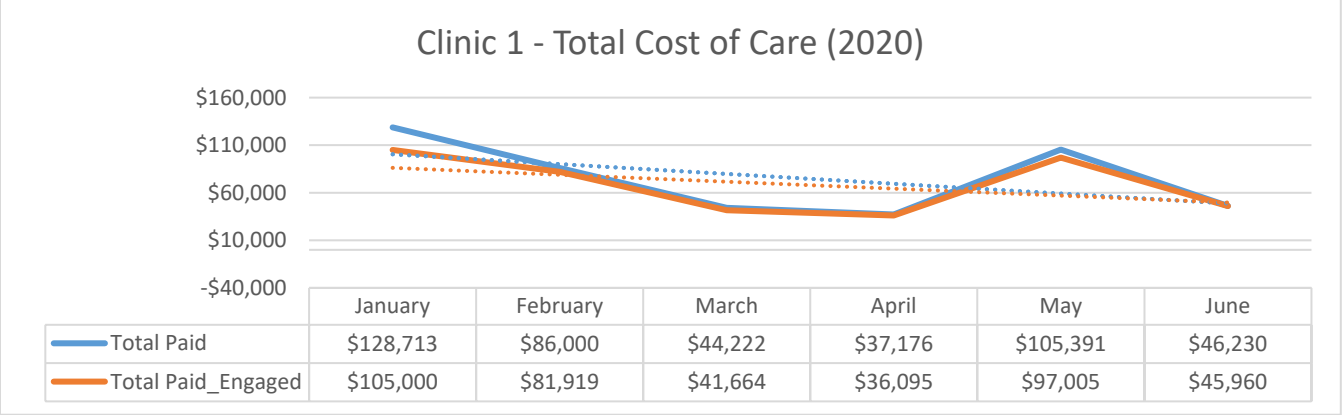
A licensed clinical psychiatric continued to provide consultation for both clinics to YCCO members as part of the BHC initiative.

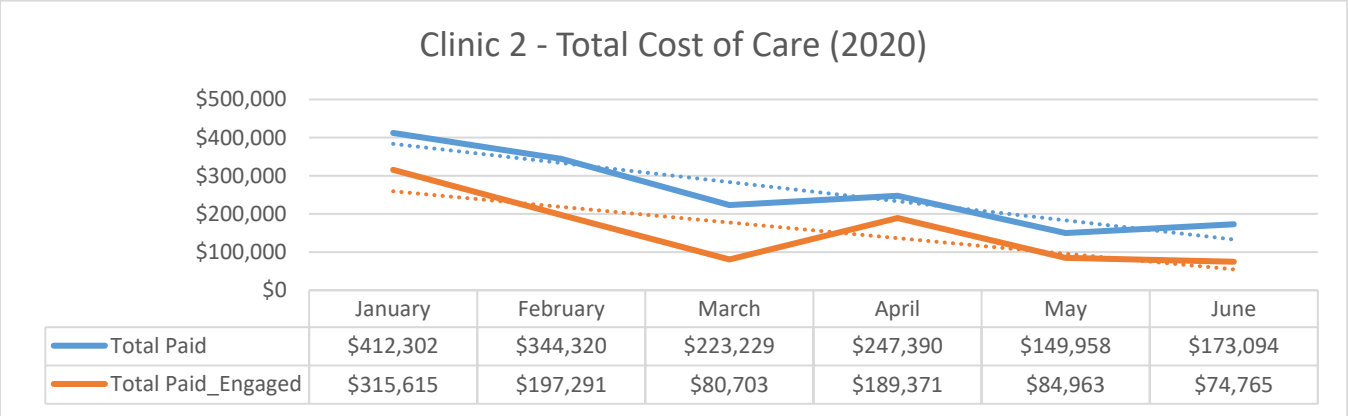
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Both clinics saw decreases in both emergency department utilization as well as total cost of care for their cohort of members in the first six months of the year.





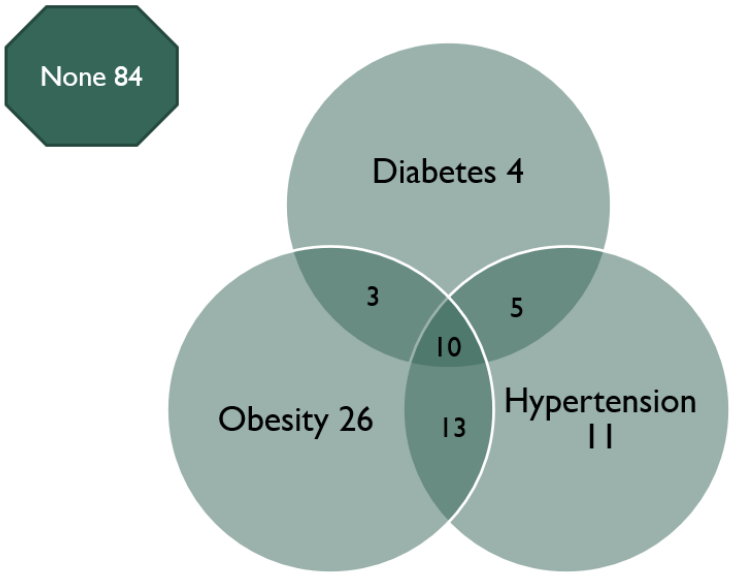




	January	February	March	April	May	June
Total Paid	$412,302	$344,320	$223,229	$247,390	$149,958	$173,094
Total Paid_Engaged	$315,615	$197,291	$80,703	$189,371	$84,963	$74,765

E. **Brief narrative description**:

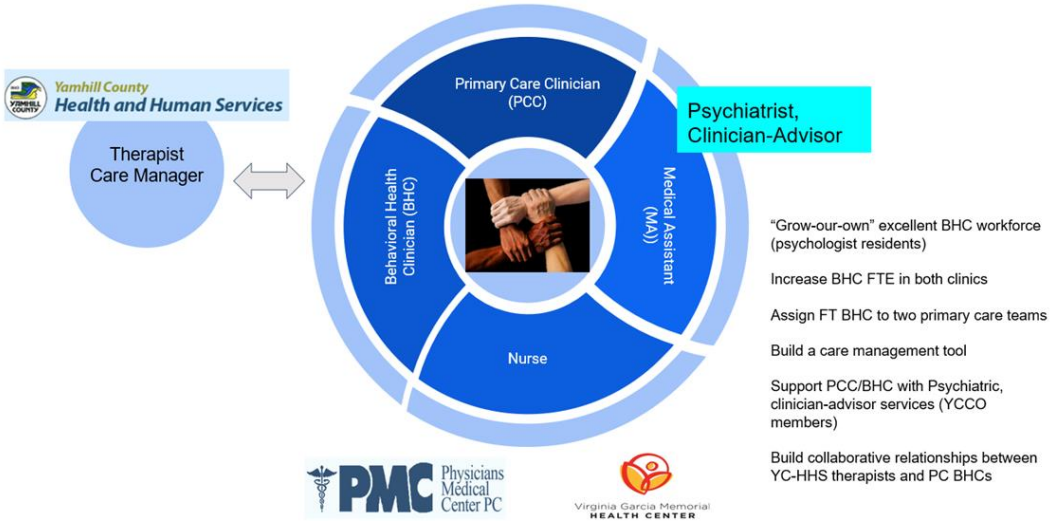
High service utilizers (e.g. 5 ED visits/12 months, total cost of care > $1k/12 months etc.) constitute about 5% of YCCO patients yet consume 50% of overall costs. It is noted that a high percentage of these patients have mental health issues, substance abuse issues, or both. Many of these members also have other comorbidities such as diabetes, hypertension, and obesity. The social determinant of health (SDOH) of Health and Health Care is a determinant area that disproportionately impact individuals with behavioral health challenges. According to the World Health Organization (WHO) individuals with severe mental disorders have a 10-to-25-year life expectancy reduction and most of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension. One of the study clinics broke down the comorbidities of their members as demonstrated below. This will help inform all the needs of a particular member. By managing the behavioral health needs of a member, the hope is that the physical health conditions will improve as well. These components will be a part of the data collection process by the participating clinics in 2021.



Studies also show that those with SPMI are more likely to have difficulty navigating the healthcare system, so they misuse the Emergency Department more often that those who do not have a diagnosis of SPMI. This project aims to improve biopsychosocial primary care for all patients, with a coordinated and integrated

model of care. Members being able to access Primary Care services as well as receive behavioral health supports allows for better access for members who otherwise would have to travel to multiple locations to receive care. The ability for the Primary Care Team to consult with a psychologist on medication management for members who are otherwise not able to readily access a behavioral health prescriber has been life changing for many of the members in the program. This is demonstrated in regular qualitative data that is collected from the participating clinics at quarterly meetings. Physician's Medical Center and Virginia Garcia McMinnville have entered into agreements to coordinate integrated care around patients, and track and share data with each other and YCCO.

Yamhill Community Care hired a subject matter expert to develop workflows that will better support those who have an SPMI diagnosis within two pilot clinics. YCCO supported these clinics to hire an additional behavioral health professional (either a LCSW or psychologist) to better support these members. YCCO also supports time for each clinic to consult with a psychiatrist to aid in evaluation and medication recommendations. There is also work within this group to increase use of The Collective Platform within this cohort of members. The clinics will be entering a care plan for each member they engage to let the ED doctors know they are enrolled in the program and any special considerations that should be considered while delivering care to the member while in the ED. Identifying these members in a cohort within the Collective Platform will also notify the care coordinator for the program at the PCP clinic that the member has been in the ED, so follow up care can be coordinated within 72 hours of discharge.



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

Activity 1 description: A Behavioral Health Clinician has been hired at each site. Hiring of coordinators was challenging due to COVID and as such the hiring process took longer than originally anticipated. PMC has also hired a coordinator to assist in this work. Both clinics are now engaging members in the model. They are using a variety of outreach techniques to engage this population, including telehealth due to COVID. Data is being collected on each member as appropriate and clinic staff will begin to report out quarterly to YCCO on their progress.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement : Clinics will report quarterly on the number of members that they have engaged in the Behavioral Health Neighborhood (BHN). They will also collect data on not only the progression of mental health condition markers such as PHQ-9 and GAD-7, but also on blood pressure, HbA1C and number of members in the cohort who have a BMI over 30. As members are engaged in the program to better support their behavioral health needs, the hope is that improvement in other health condition indicators will be observed. For 2021, a new cohort list is being provided and the contract was expanded to include data tracking of non-cohort YCCO members. Data tracking for non-cohort members will be the same as the cohort members data listed above. YCCO will assess for data trends over time to assess for ED utilization patterns, health improvement, and potential outcome pattern differences between the cohort and non-cohort group data. Data will be used to inform future project decisions.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
This population has limited quality engagement with primary care. There is also inconsistent screening of this population to address certain conditions.	Pilot clinics will engage these members (new cohort) and enroll them in this program. There will be constant touches from the clinical staff and regular screening for defined clinical and mental health conditions.	09/2021	5-point reduction in mean PHQ-9 mean score of the cohort. 50% of patients enrolled in the cohort will see reduction in weight, BP or HbA1C	03/2022

Activity 2 description : Create a sustainability plan. Currently this work is being seed funded by YCCO. The funding is being continued for another year due to COVID challenges. Now that the project work has begun, there is a need to create a sustainability plan to keep the work moving past the funding that is being provided by YCCO.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement : YCCO will collect ED and Inpatient stay data on the cohort from each clinic as well as total cost of care to show that the model is working. Clinics involved in the cohort will survey their providers on the program to evaluate for provider satisfaction and impacts on burnout in Primary Care. YCCO will track and evaluate preventative services sought by these members.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline data is being compiled on the current and	Reduction in ED and Inpatient stays for these members.	09/2021	10% reduction in overall cost of care for these members.	03/2022

new cohort of members who were identified by YCCO as target members for this program	Improve provider satisfaction. Increase in preventative services by these members.		Providers will understand how to refer patients into the program and will see the benefits of doing so. 50% increase of identified patients who engage in one or more preventative service.	

A. Project short title: **Infrastructure Development for the Tracking of Timely Access**

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

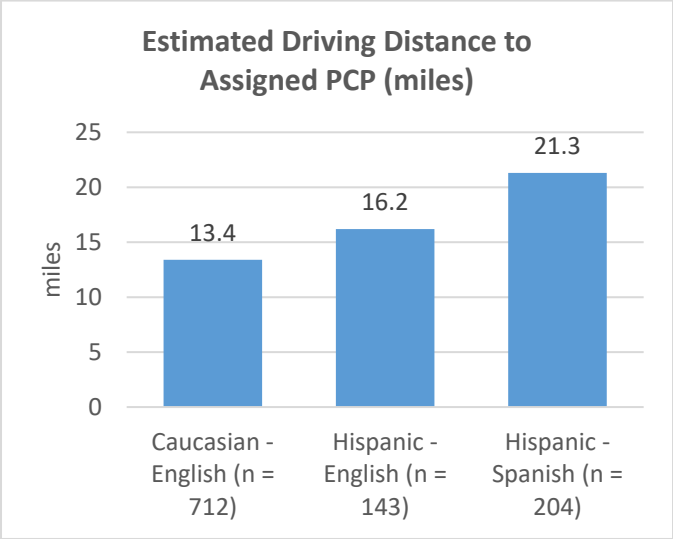
If continued, insert unique project ID from OHA: **179**

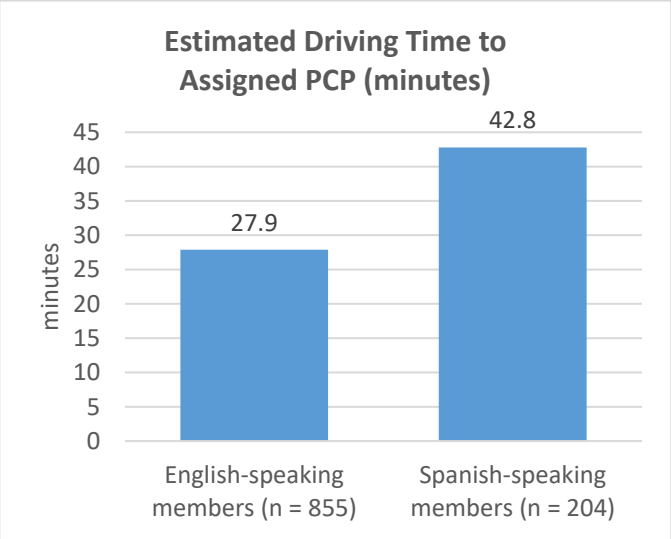
B. **Components addressed**

i. Component 1: Access: Timely
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.

In early 2020, YCCO determined that in some cases a member's race/ethnicity and primary language resulted in measurable inequities in access to their assigned Primary Care Provider (PCP). Specifically, among members living in Urban areas (as designated by the OHA dashboard), average estimated driving distance to assigned PCP for English-speaking Caucasian members (n = 712) was calculated to be 13.4 miles, 16.2 miles for English-speaking Hispanic members (n = 143) and 21.3 miles for Spanish-speaking Hispanic members (n = 204). Furthermore, among these same members, estimated driving distance to assigned PCP was determined to be approximately 15 minutes greater for Spanish speakers than for English-speakers. The primary goal of this project was to establish a dashboard to better quantify and understand the effects of a member's race and primary language on their access to their assigned PCP. A secondary goal was to identify un-engaged members who live a significant time/distance (>30 miles estimated driving distance or >30 miles estimated driving time) from their assigned PCP as candidates for reassignment to a closer PCP to reduce these inequities.





Effects of race/ethnicity and language on access to assigned PCP (February 2020)

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

In 2020 a dashboard was developed to provide more granular and specific information about members who do not live within convenient driving time/distance from their assigned PCP, defined as >30 miles and/or 30 minutes for members living in rural areas, and >60 miles and/or 60 minutes for members living in rural areas. This dashboard combines information from the bi-weekly Member Engagement Report the most recent OHA dashboard, and the locations of YCCO's PCPs to generate a list of members who live furthest away from their assigned PCP. Users of the dashboard can filter based on race/ethnicity, primary language, 24-month engagement status, members in rural or urban areas, and whether the report will issue based on estimated driving distance or estimated driving time.* Note that at this time the dashboard is not able to integrate disability status, but that plans are in place to include this by Q3 2021.

	Est. Driving Time (minutes)	Member ID	Home Address	Home City	Assigned PCP
1	56.6			HILLSBORO	The Childrens Clinic - Portland
2	56.6			HILLSBORO	The Childrens Clinic - Portland
3	49.9			SHERWOOD	Providence Medical Group - Newberg
4	47.7			SHERWOOD	Providence Medical Group - Newberg
5	47.7			SHERWOOD	Providence Medical Group - Newberg
6	47.7			SHERWOOD	Providence Medical Group - Newberg
7	47.7			SHERWOOD	Providence Medical Group - Newberg
8	47.4			SALEM	Virginia Garcia MHC - McMinnville Clinic
9	43.9			SALEM	Virginia Garcia MHC - McMinnville Clinic
10	42.7			HILLSBORO	Hillsboro Pediatric
11	42.6			HILLSBORO	Hillsboro Pediatric
12	42.6			HILLSBORO	Hillsboro Pediatric
13	42.4			HILLSBORO	Hillsboro Pediatric
14	42.3			HILLSBORO	Hillsboro Pediatric

Parameters	
Language	SPANISH
Ethnicity	HISPANIC
Engagement Status	Y
Urban/Rural	Urban
Distance/Time	Time
Total members	106
Average Straight Line Distance to PCP (miles)	6.6
Est. Average Driving Distance to PCP	9.3
Est Average Driving time to PCP	18.6
# of Members > Maximum Driving Time	31
% of Members > Mamimum Driving Time	29.2%

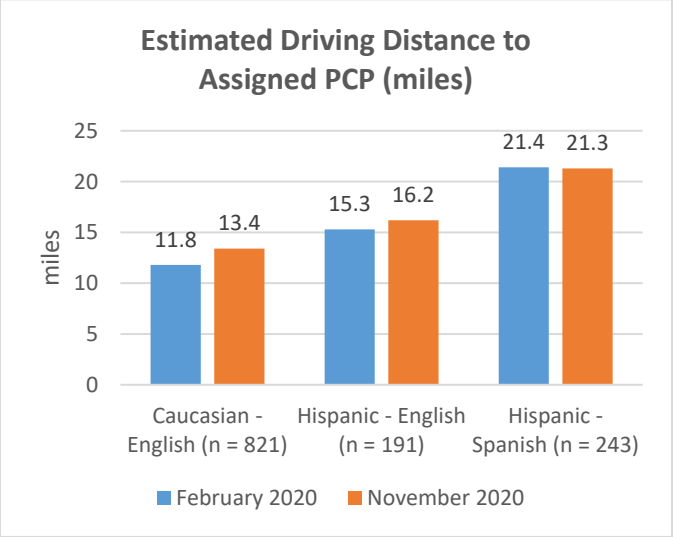
Screenshot from dashboard (member ID and address redacted to preserve privacy of PHI)

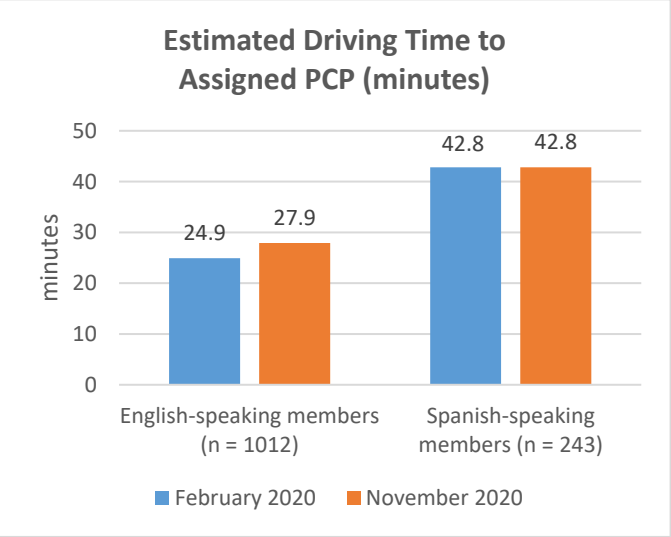
**Estimated straight line distance* – *Calculated by applying the latitude and longitude of each member's home address and the latitude and longitude of each PCP's address to the haversine formula for calculating straight line distance between two points over the surface of the Earth (Distance = ACOS(COS(RADIANS(90-Lat1)) *COS(RADIANS(90-Lat2)) +SIN(RADIANS(90-Lat1)) *SIN(RADIANS(90-Lat2)) *COS(RADIANS(Long1-Long2))) *3958.75)*

Estimated driving distance – *Estimated straight line distance X 1.4*

<u>Estimated driving time</u> – Assumes average driving speed of 29.8 mph → Estimated driving distance / (29.8/60)

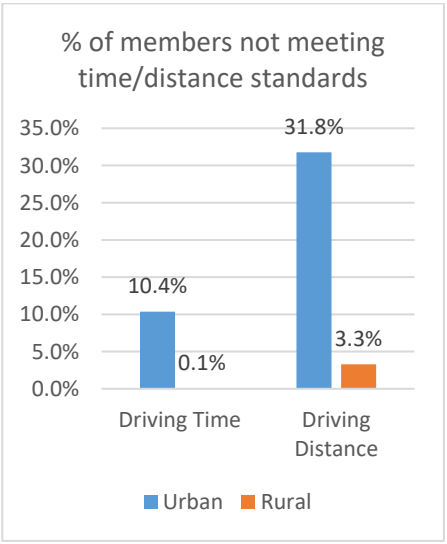
The most recent version of the dashboard shows that the trends identified in February 2020 remained largely unchanged in November 2020.

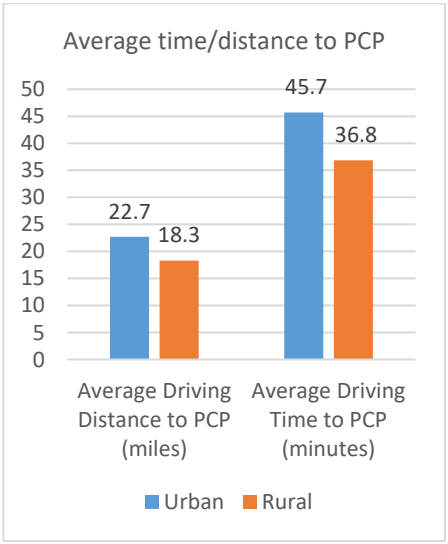


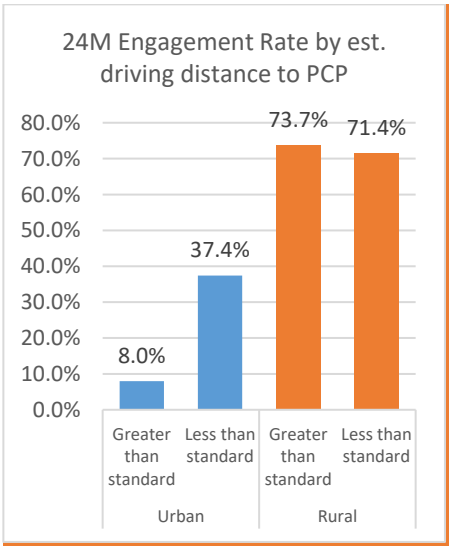


Effects of race/ethnicity and language on access to assigned PCP (February/November 2020)

Additionally, the dashboard also confirms that members not meeting time/distance standards are concentrated in urban areas, and that, even taking into account the higher time/distance standards for members living in urban areas, the average estimated driving distance to assigned PCP for members living in urban areas is greater than for those in rural areas in absolute terms (22.7 miles vs. 18.3 miles). And, while 24-month engagement rate is lower for members in urban areas to begin with, this effect is much more pronounced for members exceeding the estimated driving distance standard to their assigned PCP.







Given that YCCO's population is more linguistically and racially diverse in urban areas than in rural, addressing inequities in access to PCP has the potential to make a meaningful and quantifiable difference in quality of care for YCCO's members. In November 2020 the dashboard identified 427 non-engaged members in urban areas who live greater than 30 estimated driving miles from their assigned PCP, and 1310 members who live 30 estimated driving minutes from their assigned PCP. If a portion of these members could be reassigned to a new PCP closer to their home at the beginning of 2021, it would be possible to determine whether a closer assignment results in greater levels of engagement in care.

E. **Brief narrative description**:

This project has three goals:

i. Determine whether changing a members' assigned PCP from one exceeding the time/distance standards for their area increases engagement in care.
   a) **To be achieved by** re-assigning a portion of unengaged members in urban areas to a PCP closer to their home by the end of Q1 2021, and then comparing the 24-month engagement rate to the rate for members who were not reassigned.

ii. Reduce the discrepancy in estimated driving time to assigned PCP between English-speaking Caucasian members, English-speaking Hispanic members, and Spanish-speaking Hispanic members to less than five minutes by the end of 2021.
   a) **To be achieved by** prioritizing Spanish-speaking members in initial PCP re-assignments.

iii. Increase the percentage of all members in urban areas who meet the 30-minute estimated driving time benchmark by 10% by the end of 2021.
   a) **To be achieved by** regular monitoring of the impacts of re-assignments on the overall estimated driving distance to assigned PCP and adjusting as necessary.

The dashboard described above will be used to inform strategic targeting of PCP re-assignments, and to measure their subsequent impacts. Re-assignments will be conducted during Q12021, and then monitored quarterly through the remainder of the year. At the end of 2021 a report will be compiled describing the results of these re-assignments on member engagement and in achieving the goal of reducing disparities in PCP access based on language and race/ethnicity. This report will be used analyze the effectiveness of re-assignments at increasing engagement with care, and to inform their future maintenance and/or expansion.

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

Activity 1 description: Identify causal effects of distance to assigned PCP on engagement rate.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Causal impacts of distance to assigned PCP on engagement rate unknown.	Initial assessment of causal impacts of distance to assigned PCP on engagement rate.	12/2021	Causal impacts of distance to assigned PCP on engagement rate known within 95% confidence interval	12/2023

Activity 2 description: Reduce the discrepancy in estimated driving time to assigned PCP between English-speaking Caucasian members, English-speaking Hispanic members, and Spanish-speaking Hispanic members to less than five minutes through re-assignment of unengaged members to PCPs closer to their home address.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Estimated driving distance to assigned PCP for English-speaking Caucasian members is 9.6 miles less than for Spanish-speaking Hispanic members.	Reduce this discrepancy to five miles or fewer	12/2021	No significant race/ethnicity or linguistic discrepancies in PCP access.	12/2025

Activity 3 description: Increase the percentage of all members in urban areas who meet the 30-minute estimated driving time benchmark by 10%.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
As of November 2020, 906 unengaged members in urban areas exceed the 30-minute estimated drive time standard.	Bring at least 100 additional members in urban areas within the 30-minute estimated 30 drive time standard.	12/2021	Fewer than 10% (~400 members) exceeding 30 estimated driving minutes from assigned PCP.	12/2025

G. **Project short title**: **Supporting Members Who Experience System Barriers**

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

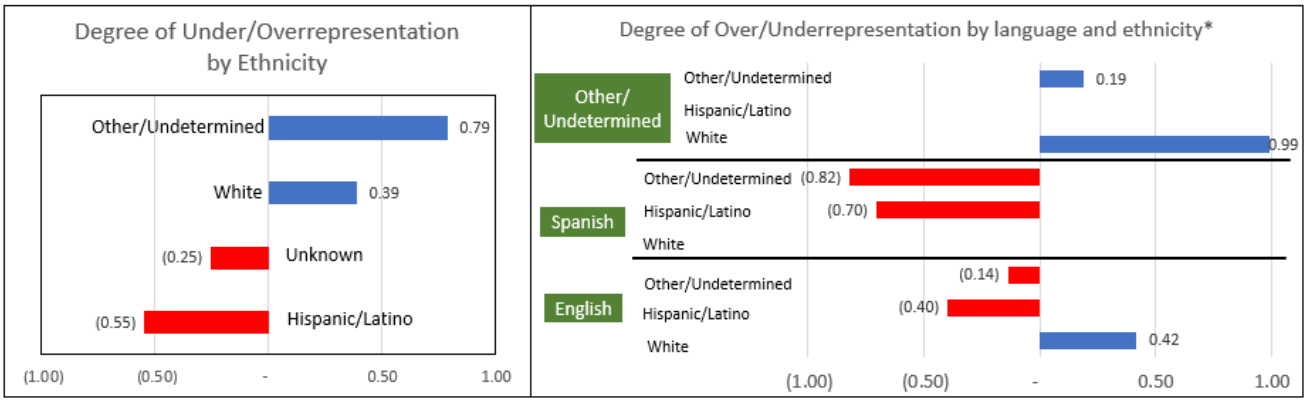
If continued, insert unique project ID from OHA: Add text here

H. Components addressed

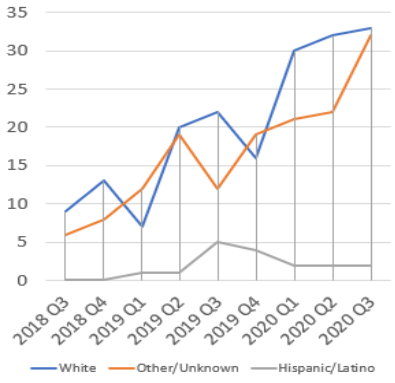
i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Access: Cultural considerations
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, 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? 14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints

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

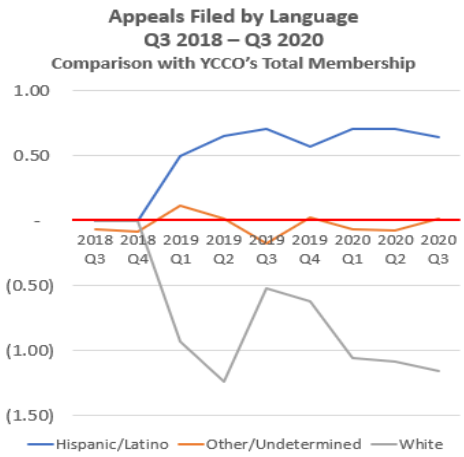
Through the review and ongoing analysis of the grievance and appeals system, YCCO recognizes that there are opportunities to improve accessibility to the system and processes and ensure all members who able to access and interact with the systems. Analysis of grievances data by ethnicity and reported language found that when compared with YCCO total membership, grievances are filed disproportionately by white, English speaking members. Grievances are also disproportionately under-filed by Spanish speaking members of all ethnicities.



For appeals, there was a similar finding that when accounting for the full YCCO population, appeals are also disproportionately under filed by Hispanic/Latino members.



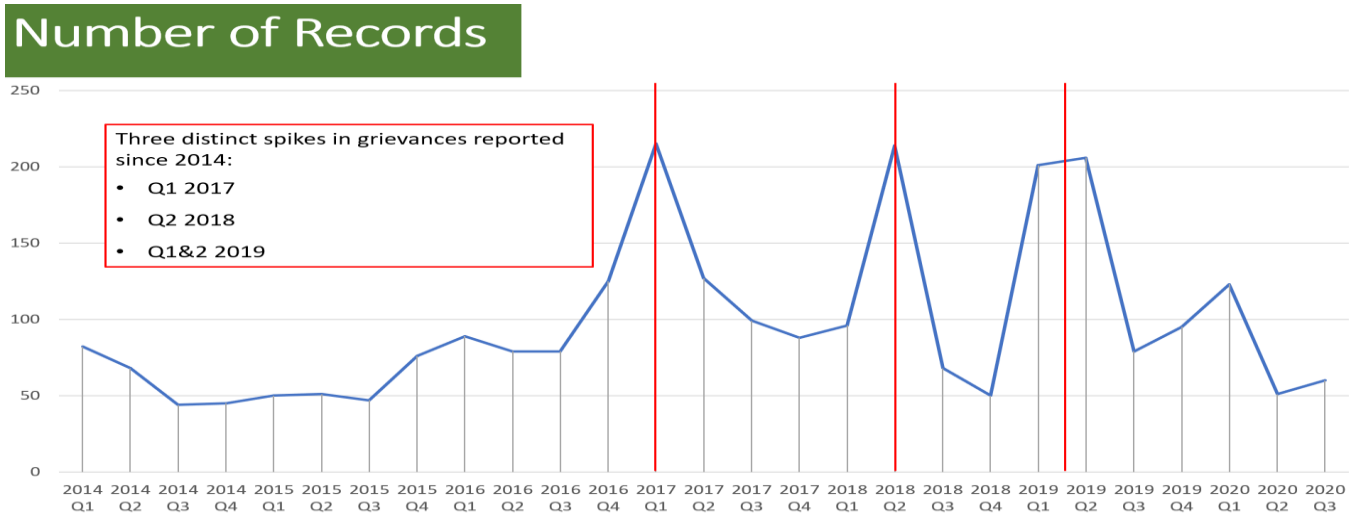
	White	Other/ Undetermined	Hispanic/ Latino
2018 Q3	9	6	0
2018 Q4	13	8	0
2019 Q1	7	12	1
2019 Q2	20	19	1
2019 Q3	22	12	5
2019 Q4	16	19	4
2020 Q1	30	21	2
2020 Q2	32	22	2
2020 Q3	33	32	2

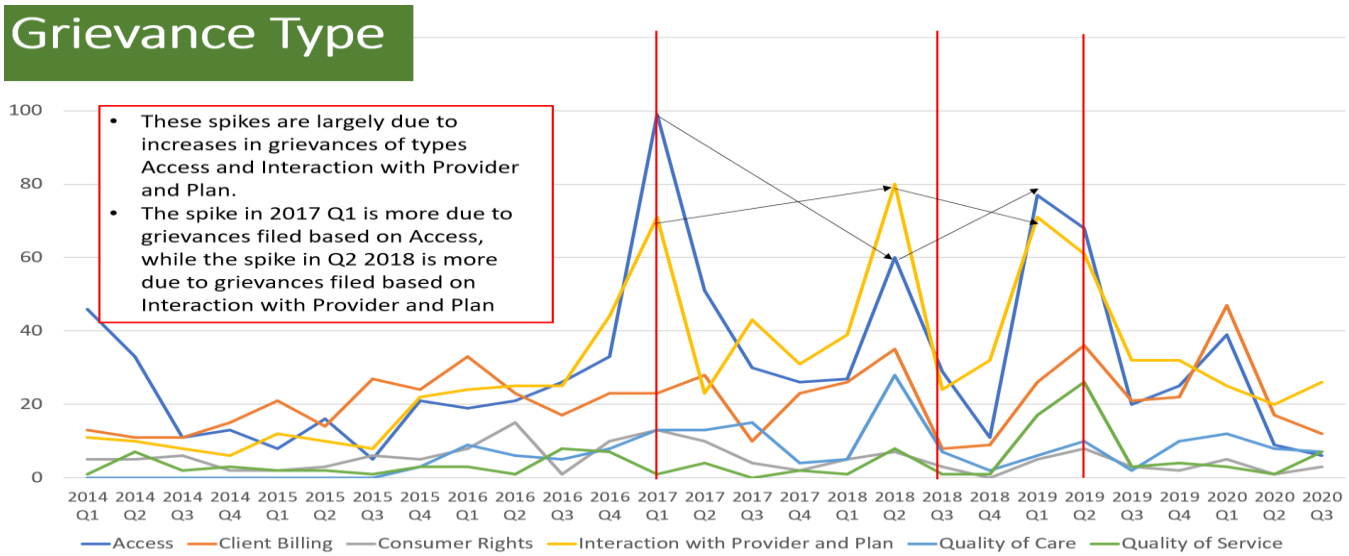


J. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

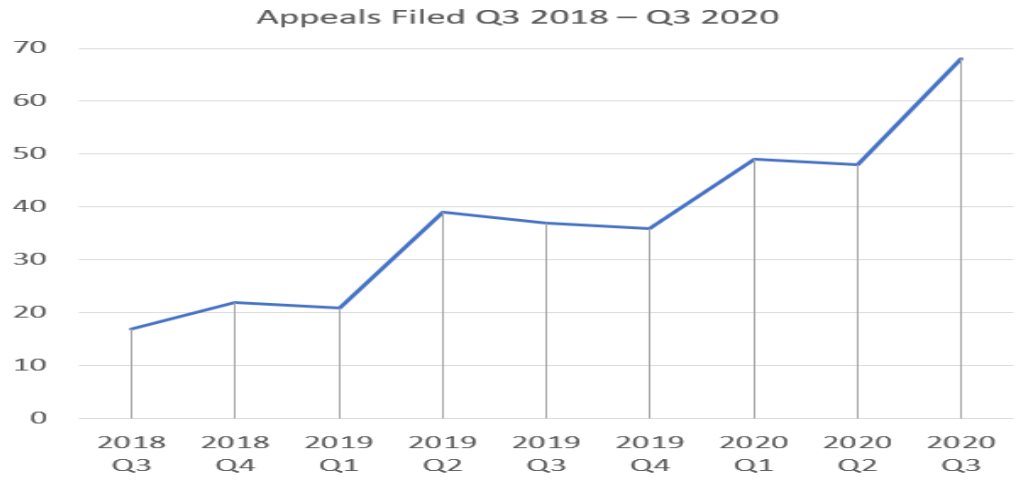
Members who identify as Hispanic or Latino or speak Spanish as their primary language experience the grievance and appeals systems at a disproportionate rate based on data shown above. YCCO knows that it is unlikely that these members are not experiencing barriers to accessing services at a lesser rate and more prominently due to other factors such as lack of awareness, cultural norms that impact sharing concerns or communication, and system navigation challenges.

Overall grievance data shows increased reported grievances over time and that these increases are linked to spikes in reported Access and Interaction with Plan and Provider complaints.





Additionally, when a service is either denied, reduced or terminated, the appeal process gives the member rights to challenge the plans decision and received the care that they believe is needed. Appeals filed by all members have increased over time.



Members are educated of these rights to file a grievance or complaint via a variety of modes: Member Handbook, Member Rights and Responsibilities statement, corporate website, and written notices sent by mail to members, via interaction with plan and provider staff. While these required structures are in place, there are opportunities for improvement in supporting members in accessing care and alleviating barriers and adverse experiences when accessing care specifically culturally specific considerations.

In alignment with CLAS standard 14, by implementing the following strategies, YCCO seeks to continue to enhance and improve these systems to ensure a culturally and linguistically appropriate experience and identify and eliminate barriers preventing members in accessing high quality care, specifically identifying potential conflicts or complaints that are not being shared, so they can be prevented or resolved.

K. **Brief narrative description**:

The most direct way to impact members is to help support the navigation process and eliminate system barriers to both accessing culturally specific care and support in engaging in the grievance and appeals system when issues arise.

The primary strategies for this work are to use existing data and analytic studies to target specific groups of members who are disproportionately impacted and to use the YCCO services that have high member touch (Customer Service, Care Management, Community Health Hub, and Health Services Department) to work with members who report barriers to care or other adverse experiences related to their engagement with the health system. Upon point of contact or engagement, strategies include evaluating members' cultural or linguistic needs and system or care barriers they are experiencing and document in the respective systems, ensuring member participation in their care and a robust understanding of individual need. Based on these interactions, teams will work with the member to address identified barriers while also educating and aligning with the grievance or appeals systems and protocols to support the member with the challenges experienced.

Goals of this work include:

- Member facing services and staff have workflows and communication talking points for assisting members in navigating the grievance and appeals systems
- Members report an increase in the ease/comfort of accessing and understanding system processes
- Through targeted education, promotion and support, the gap for Hispanic, Latino, and Spanish speaking members shows less disparity when measured one year later

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

Activity 1 description: Review grievance and appeal data with REALD analysis to identify target populations

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Report produced and shared on a quarterly basis

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Hispanic/Latino/Spanish speaking members report adverse experiences (grievance/appeals) at a disproportionate rate	Reduce disparity among members who report grievance and appeals	12/2021	No disparities exist	12/31/2023

Activity 2 description: Evaluate and update standard operating procedures and job aids used by member touch services (Customer Service, Care Management, Community Health Hub, Health Services)

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Work documents updated

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Process documents exist to support staff in supporting members in accessing the grievance and appeals systems	100% of work documents used in daily procedures	09/2021		

Activity 3 description: Offer training to staff who perform member touch services (Customer Service, Care Management, Community Health Hub, Health Services) on how to support members in accessing culturally specific care and how to document when barriers are experienced through the grievance and appeals system

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Updated cultural specific GA training delivered

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Base training on GA system in place	Updated training delivered to member touch program staff	07/2021		

Activity 4 description: Review, update and disseminate entry screenings and exit surveys for members programs (Care Management and Community Health Hub to be measured over time

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Member challenges/barriers are documented, and experience can be reported in a discreate way

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
GA data collection and reporting systems; member intake screenings and post service surveys in place. No baseline established.	Establish baselines for member reported ease in and comfort with interacting with the grievance systems	12/2021		

A. Project short title: Primary Care Capitation Pilot

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

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

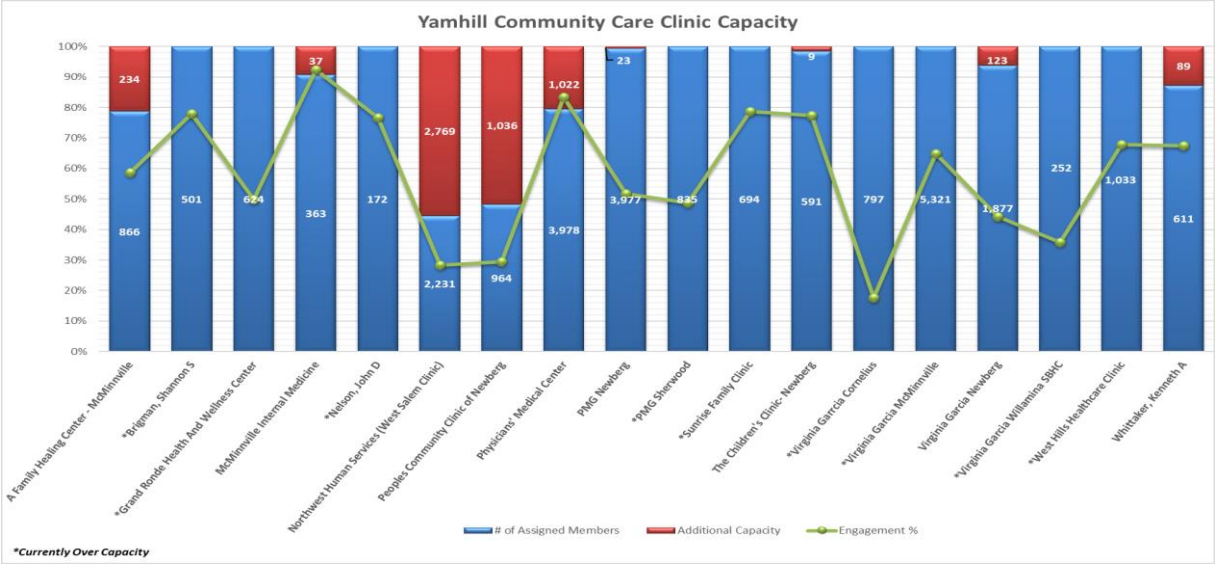
B. Components addressed

i. Component 1: PCPCH: Member enrollment
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Utilization review
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

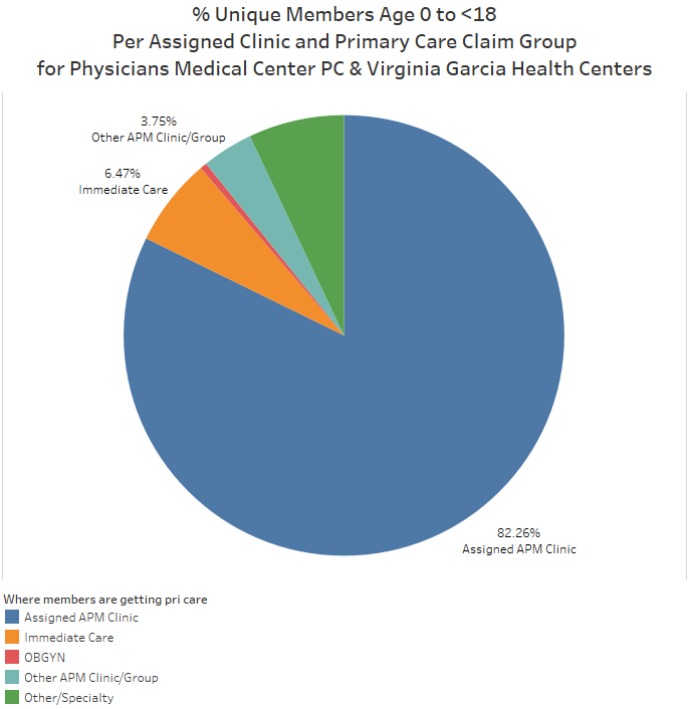
C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

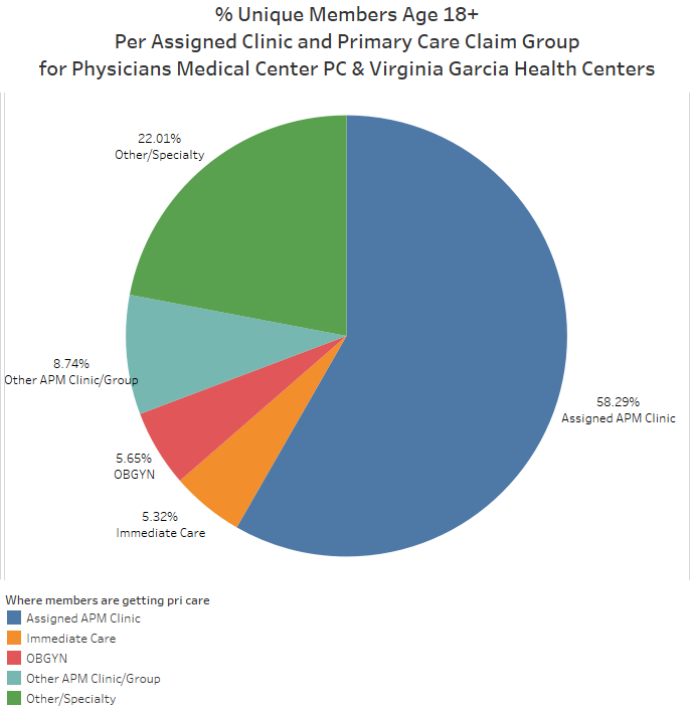
YCCO already has an established and effective Value Based Payment (VBP) program for primary care services, build upon a pay-for-performance chassis that qualifies as a Health Care Payment Learning Action Network (LAN) Category 2C VBP. The basic structure includes three primary components: 1) a traditional fee-for-service chassis, 2) a pay-for-performance quality incentive metrics program, and 3) a foundational infrastructure payment program. The latter foundational payment program is a Per Member Per Month payment program that incentivizes pursuit of higher tier PCPCH levels, higher level member engagement rates, and clinic level staffing investments for in-house behaviorists, case managers, and/or clinical pharmacists. With the focus on PCPCH foundational payments and behavioral health integration within CCO 2.0, these types of investments and constructs were prioritized as components to be carried forward in come construct within any evolved VBP models.

As noted above, YCCO's current PCP VBP model works to incentivize higher member engagement rates by paying structural add-ons on a PMPM basis for only members who have been actively engaged in the last 24 months. Even with this structuralized incentive for higher engagement, member engagement rates continue to vary greatly by clinic.



The next step was to evaluate assigned PCP engagement at greater depth. This included evaluating whether both provider and member behaviors supported and aligned with the currently assigned PCP, as well as how engagement differed across age groups (starting with 0 to 18 years of age and over 18 years of age). Analysis results provided insight into proportions of primary care services being delivered by non-assigned PCPs, Other/Specialty providers, as well as OBGYNs, especially within the 18 years and over population. Results also quantified baselines for assessing the use of Immediate Care; a potentially avoidable source of quality and coordinated care.





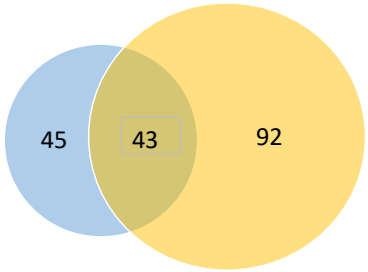
The variance in both engagement rates and member mix by primary care provider provided insight that the pilot likely required an adjustment factor for varying member mix across categories of aid. For the sake of administrative ease, the chosen direction was to move forward with three categories of aid for developing base data and provider capitation rates: Children, Active Adults, and Disabled Adults.

With the intended primary care scope of general services was also agreed upon, historical costs and experience was needed to help inform any rate modeling processes. Prior to aggregating base payment data and overall payment model structures, there need to be agreement across YCCO and the consulting provider on a targeted set of PCP-based CPT codes and services to include under a capitation model for population health management. YCCO also wanted to be conscious of and embrace currently utilized capitation agreements within YCCO's PCP network, so that where possibly YCCO could align across CCO regions and simplify administrative burden for the PCPs. To this point, YCCO and the participating pilot clinics engaged in reviewing and comparing potential CPT codes for inclusion and exclusion in the initial model. For the sake of initial risk, generally accepted PCP specific codes that could be influenced by providers were targeted (primarily Evaluation and Management codes), as well as those that comprised a significant amount of the total spending/costs within the PCP clinics. Results identified 43 codes that overlap the CPT codes OHS recognizes as PCP services and the participating pilot clinic's current capitation model; 34 of which were actively used by YCCO PCPs in 2018 and 2019. Those 34 CPT codes also accounted for over 95% of the associated primary care costs in 2018 and 2019.

Summary of paid professional claims for the PCP pilot clinics in 2018-2019.

Summary of actively used CPT code counts as they appear on one or both list of codes.

CPT Codes by List	Code Counts	Active Code Counts	% of Total Claims	% of Total Claim Costs
Overlapping Primary Care List	43	34	80.5%	95.3%
OHA Only Primary Care	92	32	14.9%	2.6%
Pilot Clinic Only Primary Care	45	20	4.6%	2.1%
Total (additive):	**180**	**86**	**100.0%**	**100.0%**



Once YCCO and the pilot clinics aligned on a set of services in scope, the path was paved to then pull base data, historical costs, and develop a capitation rate model. For the pilot, CY2019 encounter data for all primary care providers was chosen, as it was the most complete set of data that was not skewed by either COVID-19 impacts or programmatic differences in the CY2018 and prior experience. The same claims data was leveraged for the development of clinic specific risk adjustment factors, for which the Chronic Illness and Disability Payment System (CDPS) Plus Rx model was chosen as it aligns with the CCO and many other state Medicaid rate setting models. Furthermore, CY2019 and CY2020 clinic specific experience from the current VBP program was leveraged to help develop the necessary 2021 rate add-ons for infrastructure investments. The final CPT code set was also reviewed and adjusted to reflect any changes in standard coding (crosswalks to out of date to new CPT codes), as well as the current shift to greater use of telehealth services.

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

Rather than pursuing multiple projects, contracts, activities, and such, YCCO sought an opportunity to achieve a multitude of strategic and CCO 2.0 priorities within one larger scoped project. Thus, YCCO chose to pursue the primary care capitation VBP pilot as the vehicle to do such that. This path provides an avenue to achieve the following strategic focuses:

- Develop new or expanded VBP arrangements, ideally in pursuit of VBPs at a LAN Category 3B or higher. The developed pilot VBP built upon a Per Member Per Month (PMPM) capitation arrangement for specific conditions and services will qualify as a LAN Category 4A VBP arrangement.

- Integrate PCPCH foundational payments, varied upon PCPH tier level. The existing PCPCH VBP model utilized by YCCO already paid a PMPM payment tiered for higher level PCPCHs. That system has initially been built into the pilot capitation rates, also moving the PMPM payments from payment based upon engaged to assigned members (thus increasing annual funding).
- Incentivize increased access to quality of care, while also providing some autonomy to embrace clinic specific business models. Incentives include the use of pay-for-performance quality measures, as well as foundational infrastructure add-on PMPM rates for integration of behaviorists, clinical pharmacists, and/or case managers. Additional monitoring and potential expansion also include improved engagement between members and their assigned PCPs, as well as reduced services provided in settings that are not as coordinated (i.e. serviced provided by immediate care and un-assigned PCPs).
- Integrate risk adjustment factors, with potential for expansion to SDOH adjusters in the future. The initial pilot includes adjustment factors based upon known chronic conditions within clinic assigned membership, as well as incorporating inherent adjustments for population composition with the use of separate rates across three categories of aid.
- Develop a new or expanded VBP inclusive of a focus on Children's Health. As mentioned above, the pilot VBP includes the use of multiple categories of aid, one of which is specific to children 18 years of age and under. Post pilot, the VBP would ideally also be expanded to and adjusted for use with clinics specializing in pediatric care.
- Achieve financial stability and sustainability for both the CCO and providers, with considerations for achieving a sustainable rate of growth. With capitation, a provider will receive a consistent and predictable monthly revenue flow, rather than the traditional fee-for-service basis proven to be unstable during the recent COVID-19 pandemic. The CCO also has the ability to have greater control and predictability overachieving year-to-year per capita rate of growth at or below 3.4%, at least within capitated VBPs.
- Pursue at least partial alignment with provider VBPs that span across regions and CCOs. As a desire of CCO 2.0, and recognition that one of our pilot clinics does span across working in two regions/CCOs, the pilot worked to align at least some aspects of the final capitation model scope.

E. **Brief narrative description**:

This project has five overarching goals:

1. Implement a pilot with YCCO's two primary care providers if greatest assignment, with the goal to fine tune the operational details and pain points prior to the expansion to more providers, metrics, and service integration.
    a. To be achieved by ensuring an iterative pilot implementation process, inclusive of active and ongoing provider communications, grace periods for rule changes such as referral requirements, and quarterly progress reviews/monitoring.
2. Operationalize a platform in which providers operate under a population health management focus (freedom for business models, increased member engagement, etc.) and are responsible for managing the utilization of assigned members.
    a. To be achieved by moving to a capitation model that is inclusive of the majority of actively used primary care code sets, with risk adjustment aspects to address variations in population mix and morbidity.
3. Increase member engagement with assigned their PCP/PCPCH resulting in better quality of care, total cost of care savings, reduced ED/Immediate Care use, etc.

a. To be achieved by updating CCO member assignment rules, referral requirements, and member communications, as well as Provider autonomy in leveraging the strengths and efficiencies within their individual operations to deliver care.

4. Increase HIT infrastructure, supports, and resources to empower providers in improving care delivery/population health management, as outlined within the YCCO HIT strategic plan.
   a. To be achieved by:
      i. Population health and risk management strategies within the YCCO HIT strategic plan, to include but not limited to risk-based cohort sharing with providers via current and future HIE and CIE platforms.
      ii. HIT system supports for administering and monitoring Value Based Payment arrangements, inclusive of but not limited to provider portals, quality metrics monitoring programs, and claims data warehouse analyses and dashboards.

5. Promote workflows to address over utilization patterns and referral to care coordination programs (Collective identification and stratification, Intensive Care Coordination, multidisciplinary Team consults) follow-up after emergency department visits and inpatient hospitalizations.
   a) To be achieved by:

      i. Provide technical assistance to contracted hospital systems to determine members assigned PCP prior to facilitating referral for follow-up.

      ii. Communication and data sharing with contracted PCP/PCPCH clinics regarding verification of member clinic assignment prior to scheduling visits.

      iii. Training of contracted network on member assignment verification, re-assignment and referral process.

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

Activity 1 description: Evaluate the financial impacts and viability of capitation payments, inclusive of any degradation of encounter submissions and fee-for-service equivalence.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CY2019 and CY2020 actual primary care costs, both FFS and APM.	The combined FFS equivalent of submitted encounters and APM equivalent payments equate to within +/-10% of actual capitation payments to pilot clinics.	01/2022	Sustainable PCP capitation budget growth in alignment with 3.4% annual ROG goals, adjusted for increased services and PCPs.	12/2025

Activity 2 description: Improve member engagement rates with primary care, inclusive of increased engagement with the assigned PCP clinic.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement:

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CY2019 24-month engagement rates and provider engagement splits.	24-month member engagement rates are at or above historical rates for pilot clinics.	12/2021	Reduced use of avoidable specialty referrals and non-assigned PCP engagement across all PCPs.	12/2025

Activity 3 description: Improve member utilization rates with primary care, and acute care by encouraging assigned PCP engagement in care management activities.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Care Management (CM) engagement for members with high emergency room utilization using the Collective and Multidisciplinary team (MDT) to track.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Members with undesired utilization patterns identified	Increase in CM and MDT referrals from PCP Capitated providers	12/2021		

Section 2: Discontinued Project(s) Closeout

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

A. Project short title: **Assess Current Member Communication from Provider Network (Appointing, AVS, Member Education Materials)**
B. Project unique ID (as provided by OHA): **175**
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): After fielding a survey to network providers and evaluating EHR adoption and the utilization of patient portals to assess current state of member communications generated from the provider network, the following was learned: based on survey results, there are varying degree of workflows established to support members with limited English proficiency; a lack of understanding of the requirements regarding communications

with Medicaid members was observed; while many clinics have the capacity to offer an online patient portal, the ability to collect data from these portals or customize them is limited. Based in these learnings, YCCO has decided to abandon this specific project as there are other foundational activities that need to be in place before this project can be successful. Resources will be redirected to Project 2 activities to continue assessment of network providers ability to offer language services for its members via language access reporting and the creation and dissemination of a provider tool kit to support providers in understanding Medicaid language service requirements and workflow to offer quality services.

A. Project short title: **Cultural Responsiveness Training**
B. Project unique ID (as provided by OHA): **This Project Was Removed from the 2020 TQS as part of the Resubmission Process**
C. Criteria for project discontinuation: Project fails to meet TQS guidance in requirements for the chosen component(s) based on OHA feedback and/or written assessment
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): In YCCO's resubmission of its 2020 TQS, this project was removed based on guidance from OHA and on YCCO current distribution of resources and priorities. Additionally, as its Equity Plan was developed and further guidelines from the Office of Equity and Inclusion released, offering cultural responsiveness training directly to its provider network is not within the purview of YCCO. Instead, YCCO will monitor provider compliance with cultural responsiveness training as related to certification and licensure requirements and ensure trainings related to these topics are offered by OEI-approved vendors.

A. Project short title: **Equity-based Assessment and Analysis of the Delivery of NEMT**
B. Project unique ID (as provided by OHA): **178**
C. Criteria for project discontinuation: Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Analysis of the data indicated that there is a disparity of NEMT users who speak other languages with the majority of the service used by English speakers and this is also true in the Grievance system space. YCCO will continue to do additional analysis to further understand the disparity and potential cause based on information from customer service claims and grievances. YCCO is using the data gathered to populate new grievance projects where it could be better operationalized.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).
   1) YCCO Quality and Clinical Advisory Panel Charter
      2021 TQS QCAP Presentation
      YCCO QCAP Minutes 2-23-2021

   2) <u>Quality Assessment Performance Improvement Annual Monitoring:</u>
      Grievance System 2020 Annual Report
      2020 Metrics Update Year-End
      Accessibility Survey 2020
      <u>Subdelegate Oversight</u>
      2020 Q2 YCCO Behavioral Audit Findings – Redacted

2020 Q2 YCCO Dental Audit Findings – Redacted
2020 Q2 YCCO NEMT Audit Findings – Redacted
2020 Q2 YCCO Pharmacy Audit Findings – Redacted
2020 Q2 YCCO Physical Health Audit Findings – Redacted
2020 Q3 YCCO Behavioral Audit Findings – Redacted
2020 Q3 YCCO Dental Audit Findings – Redacted
2020 Q3 YCCO NEMT Audit Findings – Redacted
2020 Q3 YCCO Pharmacy Audit Findings – Redacted
2020 Q3 YCCO Physical Health Audit Findings – Redacted

3) Quarterly analysis GA; two quarterly NOABD audit findings; SLA; NOABD audit template
   2020 SLA CDC Cumulative
   2020 SLA PH TECH Cumulative
   2020 SLA Providence Cumulative
   2020 YCCO NOABD Audits (Redacted)

4) YCCO 2020 EQR IP - Standard VII Member Rights

5) YCCO QCAP Minutes 2-23-2021
   YCCO QCAP Minutes 5-26-2020
   Compliance Committee Minutes 2-9-2021

6) P&P TRACKING FORM

B. OPTIONAL: 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.
   - QPI-001 Quality Program and Performance Monitoring
   - YCCO Plans
   - TQS Matrix

C. OPTIONAL: Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Add text here.
   - YCCO Service Area and Demographics

Submit your final TQS by March 15 to CCO.MCODeliverableReports@state.or.us.