Contents

Section 1: Transformation and Quality Projects

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

Project 91: Improvement and Stratification of Health Equity Data

A. Project title: Improvement and Stratification of Health Equity Data

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

If continued, insert unique project ID from OHA: 91

B. Components addressed

1. Component 1: CLAS standards
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**

   Over the last year, EOCCO has continued to improve our data collection capabilities. Data is received through a variety of sources including screening tools such as Accountable Health Communities (AHC), Unite Us data feeds, Arcadia Analytics, and supplemental intake resources. These data streams capture a variety of demographic indicators and are intended to supplement the information received in OHA's 834 intake files to provide a more comprehensive understanding of the member population we are serving. While EOCCO is interested in improving the overall quality of our collection, this project has a specific focus on reducing the number of members who have data values such as *not provided, not applicable,* or *not assigned* listed in their race/ethnicity field. Currently, 23.12% of EOCCO members have an unknown race/ethnicity in their member profile.

   To assist in this process, EOCCO focused on integrating data collected using the AHC screening, which consistently provided more complete demographic results than other sources of data. Screeners were administered to individuals who had two or more emergency department visits within a twelve-month period. Individual emergency department encounters were captured by PointClickCare (formerly Collective), an online platform that helps coordinate care and monitor emergency department utilization. PointClickCare generated weekly reports on EOCCO members who met the two-or-more-visit threshold. EOCCO then partnered with the Oregon Rural Practice-Based Research Network (ORPRN) whose trained screeners would contact members and asked if they would be willing to complete a social needs screening and a supplemental REALD questionnaire. Screenings were conducted in the member's preferred language with the help of contracted language services provider, Passport to Languages.

   During the first year that AHC screenings were administered (2022), there were over 350 screenings completed despite the fact there were several months where no screenings occurred due to a temporary lapse in funding. This suggested that with a full twelve months of funding, EOCCO would be able to serve even more members. However, in 2023, only 108 AHC screens were completed. This was a 67% decrease compared to the number of screens completed in 2022 (n=323). Of those 108 screenings, only thirteen entries provided updated information for members' race/ethnicity that was previously unknown (less than a 0.01% reduction in unknown values). A REALD-GI analysis was completed on the total number of AHC screens conducted in 2023 to stratify

languages spoken at home and disability (in addition to race and ethnicity that were previously analyzed). The analysis revealed that 40.8% of members screened spoke Spanish, which was significant for EOCCO members. Additionally, the population had higher rates of individuals who self-identified as having serious difficulty climbing stairs (25.9%), difficulty doing errands alone (25.9%) and difficulty concentrating because of a physical, mental, or emotional condition (23.1%). There was no gender identity data provided for the project population in OHA's REALD-SOGI Data Repository file, so GI analysis was not performed for this project. For additional information on the total number of calls placed and positive SDOH screening trends, see Project 91: Attachment 1 in Section 2.

Over the past year, EOCCO also began receiving the REALD-GI Repository file from OHA, which serves as another source of demographic information. Upon integration of this file, demographic information was available for an additional 231 members who previously did not have a race or ethnicity value listed in their 834 demographic files. Though the 2023 TQS project did not outline the expectation of integrating a second source of data into the warehouse, the REALD-SOGI repository file proved helpful in reducing the number of unknown values that EOCCO would not have had with the AHC screenings alone. It is worth noting that the latest OHA Repository file contained records for 2,618 members, which is roughly 3.5% of the EOCCO population. As the membership included in the Repository grows, the CCO will continue incorporating the OHA data fields into existing member demographic data files to fill in areas where REALD-SOGI data may be missing. Project 91: Table 1 displays information on updated race/ethnicity data gathered from OHA's REALD-SOGI Repository:

Project 91: Table 1. *Updated Primary Race/Ethnicity Data for Members Previously Listed as 'Unknown'*

Primary Racial or Ethnic Identity	Count of Primary Race/Ethnicity	Percentage of updated member sample
American Indian / Alaska Native	20	8.2%
Asian	9	3.7%
Black/African American	8	3.3%
Latino/a/x/e	79	32.4%
Native Hawaiian/Pacific Islander	1	.4%
Middle Eastern/North African	4	1.6%
White/Caucasian	120	49.2%
Multiracial/Other Race	3	1.2%
Grand Total	231	100%

Using both the AHC screening results (n=13) and REALD-SOGI Repository file (n=231), EOCCO was able to extract race/ethnicity information for an additional 244 members or 0.3% of the population.

Over the past year, significant resources have been dedicated to building out the EOCCO data warehouse to collect REALD, SOGI and social determinants of health (SDOH) data. Monthly workgroups were established with SMEs from across the organization to lead the strategy which prioritized various data sources for integration. Over twenty new data sources were identified, including several sources that collected information on gender identity at the time of enrollment. After reviewing each of the sources, the group finalized the data points to be built into the internal CCO data warehouse (see Project 91: Attachment 2 in Section 2 for additional details). These categories will serve as the starting point the data warehouse development. EOCCO will continue the development and data collection on these points over the next couple years.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

Last year's TQS had two timeline activities to be completed in 2023:

- Monitoring Measure 1.1: This activity sought to use AHC screenings to provide supplemental data on members' race and ethnicity to provide a more accurate and reliable depiction of our member population. By integrating an additional data source into our analysis, EOCCO hoped to reduce the total

amount of members with values such as *not provided, not applicable,* or *not assigned* listed in their race/ethnicity field by 1.5% by 12/23. EOCCO did not meet our goal of reducing unknown race/ethnicity fields by 1.5% using AHC screenings alone as this value was closer to 0.01%. We will continue to collect supplemental data moving forward.

- Monitoring Measure 2.1: In Activity 2, EOCCO aimed to identify SOGI data points to capture and build into the EOCCO data warehouse by December 2023. This has been completed for gender identity. EOCCO will continue to work towards configuring these data points into the warehouse and monitor recommendations put forth by OHA for collecting data around sexual orientation. See Project 91: Attachment 2 in Section 2 for additional information on this work.

EOCCO is optimistic that efforts in 2023 helped lay the groundwork needed not only to collect updated demographic information, but also to accurately reprogram the data warehouse to display reliable demographic information.

3. **Lessons learned over the last year:**
While there has been a heavy focus on collecting quality REALD and SOGI data both within EOCCO and as a statewide initiative, data collection is a slow process. During the first year that AHC screenings were collected (2021) we had a high rate of members opting to complete the screener and REALD questionnaire. Given the high response rate during the first year, EOCCO had anticipated seeing even more members complete screening in the subsequent years. However, the number of completed screens actually decreased in 2023. We believe that this is partially due to the changing landscape of social service programs resuming normal business practices after the COVID-19 pandemic. In order to reach a broader audience with the AHC project in the future, EOCCO is in the process of adding a Self-Referral Initiative in which an EOCCO member or their representative can fill out an online Self-Referral form and be contacted by an AHC Screener for a full social needs screening. This will expand the reach of this project to individuals who may not be engaging with the health care system, particularly the ED, and allow the CCO to gather REALD data on this population.

D. Brief narrative description

1. **Project population:**
Since this project aims to improve the overall quality of member data across the EOCCO population, it will serve all members, including communities of color, Tribal communities, persons with disabilities and individuals who identify as lesbian, gay, bisexual, transgender or queer, or who are questioning their sexual and/or gender identity.

2. **Intervention (address each component attached):**
Accurate data collection is essential to addressing health inequities that may exist between and among different population groups. Both the collection and storage of demographic data are essential to understanding the changing needs of our population and improve access and coordination of care. Going forward, EOCCO will continue to refine our AHC program outreach criteria for members who are eligible for a social needs screen beyond individuals who have had two or more emergency department visits. With these expanded criteria, EOCCO anticipates reaching out and collecting demographic information on more members through the AHC screening process. Demographic data obtained through the supplemental REALD screener and the OHA REALD-SOGI repository file will be integrated into our data warehouse and analyzed against our current member information to update any race/ethnicity values that were previously unknown. Through the integration of these two sources, EOCCO seeks to continue reducing the percentage of members with unknown demographic data. In addition to enhanced data collection strategies, EOCCO will work to capture and display data values around all REALD and SOGI categories with an immediate focus on gender identity. The buildout and migration of the internal data warehouse is a complex process, which requires contributions from teams across the organization. A Service Request has been placed with the EOCCO Data Science team who will begin developing these categories within the data warehouse. EOCCO will continue to collect updated demographic data, including SOGI information, however we will not be capable of storing it in warehouse until the buildout is complete.

This project addresses CLAS Standard 11 ("Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity incomes").

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: EOCCO seeks to increase available demographic data for race and ethnicity by using completed AHC screens and OHA's REALD-SOGI Repository file to supplement 834 data, therefore providing a more comprehensive understanding of our member population. The goal is to reduce the percentage of 'Unknown' race/ethnicity categories by 4% (to 19.1%) by December 2027.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Reduce the overall percentage of members with an unknown response for race/ethnicity using AHC screening results files and OHA's REALD-SOGI Repository.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Currently 17,382 members (23.12% of EOCCO membership) have an unknown race/ethnicity listed in the member profile.	Reduce % of 'Unknown' race/ethnicity to 21.6%	12/2025	Reduce % of 'Unknown' race/ethnicity to 19.1%	12/2027

Activity 2 description: EOCCO has identified SOGI data points for collection and will continue working with the Analytics team to begin configuring data into the data warehouse. The goal is to integrate SOGI data in EOCCO's internal member profiles by December 2026. Please note that this project is focused on building out the capabilities of the data warehouse to present SOGI data. EOCCO will continue collecting supplemental SOGI data prior to the expansion of the data warehouse, however we do not expect it to be available in our central EOCCO repository right away.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Configure data collection points to build into the internal EOCCO data warehouse.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current data warehouse does not have the capability of displaying SOGI data. Service Request to develop SOGI categories within data warehouse has been submitted to EOCCO Data Science team.	EOCCO Analytics & Data Science teams to configure identified SOGI data points into EOCCO data warehouse.	12/2025	SOGI data is integrated into and reflected in the member's profile in EOCCO's Data Warehouse.	12/2026

Project 92: Culturally Responsive Services by Community Health Workers

A. Project title: Culturally Responsive Services by Community Health Workers

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

If continued, insert unique project ID from OHA: 92

B. Components addressed

1. Component 1: Health equity: Cultural responsiveness
2. Component 2 (if applicable): CLAS standards
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** EOCCO evaluated the REALD data of all Community Health Workers (CHWs) in the service area in 2023 by leveraging existing Traditional Health Worker (THW) reporting requirements and quarterly/annual surveys to gather data on the race, ethnicity, language, and disability status of the workforce in the region. SOGI data was not gathered in 2023 but SOGI-related questions have already been added to the CCO's next annual THW Survey. Preliminary results of the analysis found that 17.12% [28.36% when excluding unknowns from the data set] of CHWs in the EOCCO service area reported speaking Spanish as their primary or secondary language and 15.32% of all CHWs were OHA certified or qualified Health Care Interpreters (HCIs) [89.47% of CHWs who speak Spanish are HCIs]. Furthermore, 17.91% [33.03% when excluding unknowns from the data set] of the CHW workforce in the EOCCO region identified as Hispanic, suggesting that the workforce is well-poised to support the 24.88% of EOCCO members who identify as Hispanic/Latino and the 15.82% of EOCCO members who indicate speaking Spanish. However, the absence of disability representation among CHWs (0%) contrasts with rates observed in other THW types, such as Peer Wellness Specialists, where disability rates reached 33.3%. This percentage also differs from the 4.32% of individuals with disabilities in EOCCO's member population. EOCCO's THW network saw unprecedented growth, with an 85% increase in THW providers and a 270% rise in CHWs. This growth potentially contributed to gaps in REALD and SOGI data reporting for 2023 and EOCCO will work to reduce unknowns in data during 2024.

   To understand what member needs should be addressed by THWs, EOCCO analyzed 10% (4,066 claims from 1,840 unique members) of all CHW claims using REALD-GI data of members who used CHW services during the 2023 calendar year. The findings indicate a similar proportion of individuals accessing and utilizing THWs compared to EOCCO's member demographics. Specifically, 59.57% of THW service users identified as white, 14.51% as Hispanic, and 3.48% as American Indian/Alaska Native. Moreover, only 5.76% of CHW users reported Spanish as their primary language, underscoring the proficiency of Spanish-speaking CHWs in assisting members. Additionally, CHWs provided services to members with disabilities, constituting 8.27% of all individuals served by CHWs. GI data availability through OHA's repository file was limited, with only 28 THW users having accessible data, all identifying as cisgender men (n=20) or cisgender women (n=8). EOCCO's data revealed 50.11% of THW service users identify as male (n=922), while 49.90% identify as female (n=918), with no available sexual orientation data.

   Once sexual orientation (SO) data is made available through the OHA Repository, EOCCO will incorporate these fields into its existing demographic file and internal Data Warehouse. Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to

identify disparities. Once disparities are identified, the CCO will examine potential root causes for these inequities and revise or create interventions to address these causes. Data on race and additional languages beyond Spanish was also evaluated for both the THW workforce and members who use THW services, but no significant disparities or findings were identified. See Project 92: Tables 1-3 for full analysis.

EOCCO also ensured the accuracy of data collection and billing claims by providing technical assistance (TA) for CHW billing. This involved meeting with providers, clinics, community-based organizations (CBOs), and THWs interested in billing, and hosting monthly THW meetings that provided training on billing procedures, up-to-date codes, and the billing process. This resulted in a marked increase in clinics reporting billing for CHW services. This success is attributed to a 221% increase in billed CHW services and a 270% increase in the CHW workforce, alongside collaborative efforts between EOCCO and clinics. EOCCO remains committed to improving reporting and billing practices for data stability, with a focus on REALD and SOGI reporting.

To address the unique needs of EOCCO's members, EOCCO conducted various culturally responsive trainings in 2023, including trauma-informed care and caring for older adults (QPR, Post Acute Care, Geriatric Depression Scale, Substance Use in Older Adults, and Powerful Tools for Caregivers). Despite staff turnover, training on CLAS standards is scheduled for Summer and Fall 2024. EOCCO also strengthened its support for priority groups, including individuals with diabetes, individuals with end-stage renal disease, Spanish speakers, and members of the Compacts of Free Association (COFA) and Healthier Oregon Program (HOP) through targeted materials, health fairs, and collaborations with CBOs. Culturally specific materials were developed and distributed by CHWs, like the "Important Phone Number" flyer for COFA and HOP members. EOCCO sponsored interpreter training for a Marshallese CHW to become a qualified HCI, with plans to translate current and future CHW materials and member-facing products into Marshallese and Chuukese. EOCCO remains committed to providing ongoing education and collaboration for CHWs serving priority populations.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   - Monitoring Measure 1.1: EOCCO surpassed the target for this measure, with 68.50% of clinics reporting billing for CHW services, exceeding the goal of 60% and marking a 14.70% increase from 2022. This achievement was driven by a 221% increase in billed CHW services and a 270% increase in the CHW workforce, along with collaborative efforts with clinics.
   - Monitoring Measure 1.2: EOCCO met the target for this measure by evaluating 10% of all CHW claims received in 2023 through a REALD lens, aligning with the established goal.
   - Monitoring Measure 2.1: EOCCO provided continuing education on trauma-informed care and caring for older adults to CHWs. The scheduling of three trauma-informed care training sessions was positively reinforced by the feedback from participants, with 90% reporting an increase in knowledge, indicating the effectiveness of continuing education opportunities especially in enhancing cultural responsiveness and trauma-informed care. CLAS standards training has been scheduled for July and September 2024, as they were omitted in 2023 due to staff turnover.
   - Monitoring Measure 2.2: EOCCO developed culturally and linguistically specific materials for targeted populations, such as COFA and HOP members, and sponsored interpreter training. Plans for translating materials into Marshallese and Chuukese were also outlined, indicating efforts to meet the target.

3. **Lessons learned over the last year:**
   Despite significant strides in integrating CHWs into healthcare services, EOCCO encountered persistent challenges in collecting SOGI data from CHWs. The substantial growth of the CHW network throughout 2023 highlighted the need for EOCCO to establish more systematic and robust mechanisms for gathering SOGI data from CHWs, possibly incorporating this process into the onboarding procedures for EOCCO's THW network. Likewise, EOCCO will aim to gather more robust REALD and SOGI data from its members to ensure more accurate analyses for the 2024 year. Please see Project 91 "Improvement and Stratification of Health Equity Data" for more details on REALD-SOGI data integration plans. Moreover, EOCCO recognized the profound impact CHWs wield in linking members of priority populations to vital community resources. This realization

underscores EOCCO's commitment to further expanding and prioritizing this aspect of their services in the coming year. Ensuring that members receive informational materials from EOCCO through CHWs, who hold positions of trust within their communities, will remain a key focus area. This strategic approach aims to enhance accessibility to healthcare resources and promote trust among members of priority populations served by EOCCO.

D. Brief narrative description

1. **Project population:**
   This project encompasses THWs and members utilizing THW services, with a clear focus on equipping and training EOCCO's THW network to provide culturally competent and linguistically appropriate services to EOCCO's members and priority populations (see Project 92: Table 1 & Table 3 for full analysis of EOCCO CHWs and members). EOCCO's analysis aims to uncover patterns in care utilization and demographic differences between THW service users (see Project 92: Table 2 for service user demographics) and non-users. Additionally, it aims to highlight any gaps between THW service providers and the community they serve, ensuring that the THW workforce reflects and adequately supports the diverse needs and demographics of EOCCO's members. Through this endeavor, EOCCO seeks to accurately analyze REALD and SOGI data to assess its ability to serve EOCCO members effectively, ensure priority populations engage with THWs, and enhance access to EOCCO's service area, including healthcare system navigation, personalized support, resources, and care coordination.

2. **Intervention (address each component attached):**
   EOCCO plans to continue both interventions from the 2023 TQS Submission. These interventions seek to bolster the sustainability and readiness of CHW-based culturally responsive care. Firstly, to ensure the ongoing viability of these services, EOCCO will continue to provide TA for CHW billing until all clinics employing CHWs are billing for services. This aims to sustain both the EOCCO CHW program and the funding and delivery of services. Consistent support and engagement with clinics and community partners, demonstrated throughout 2023, are vital for enhancing billing and data collection procedures. Key metrics, such as tracking the number of clinical partners billing CHW services and evaluating billed services through a REALD and SOGI lens will gauge effectiveness and inclusivity of THW services and the THW workforce. As such, CLAS Standard 3 will be addressed by equipping CHWs and their employer-organizations to implement CHW-based culturally responsive services through training updates, material and resource enhancements, and training provider organizations in EOCCO's CHW program.

   Secondly, EOCCO remains committed to enhancing the implementation readiness of CHW-based culturally responsive care. This involves equipping CHWs and their employer-organizations with updated training, materials, and resources to effectively deliver culturally responsive services. Evaluation of current and future CHW training opportunities will ensure alignment with identified priority populations, while diligent distribution and tracking of member materials will optimize resource utilization. These interventions aim to enhance the capacity of CHWs and their supporting organizations to deliver culturally sensitive services effectively. These efforts will address CLAS Standard 13.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: Ensure sustainability of CHW-based culturally responsive care by providing TA for CHW billing and increasing the percent of clinics billing for CHW services to 80% and evaluating 30% of CHW claims through a REALD-GI lens by December 2025. EOCCO's THW Liaison and Lead Provider Relations Representative will continue to provide learning opportunities to clinics to bill CHW services for reimbursement, discussing options for capturing and paying for the scope of culturally responsive care being provided in clinical settings by the workforce, and increasing REALD and SOGI data collection.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Track number of clinical partners billing CHW services for reimbursement using information from quarterly THW Utilization reports			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
68.5% of clinics report billing for CHW services	75% of clinics report billing for CHW services	06/2024	80% of clinics report billing for CHW services	12/2025
Monitoring measure 1.2	Evaluate billed CHW services through a REALD lens using data from claims, 834 enrollment, and OHA REALD-SOGI Data Repository			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
10% of CHW claims evaluated through a REALD lens	15% of CHW claims evaluated through a REALD and GI lens.	12/2024	30% of CHW claims evaluated through a REALD and GI lens.	12/2025

Activity 2 description: Ensure implementation readiness of CHW-based culturally responsive care by offering continuing education to CHWs on topics for priority populations by July 2025 and creating and distributing member materials for priority populations by December 2025. EOCCO will equip CHWs and their employer-organizations to implement CHW-based culturally responsive services by updating training for CHWs based on identified needs, updating the materials and resources used by the program, and training provider organizations in EOCCO's CHW program.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Evaluate current and future CHW training opportunities for alignment with identified priority populations			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CCO offered continuing education to CHWs on all the following topics for priority populations: trauma-informed care, older adults	CCO offers continuing education to CHWs on all the following topics for priority populations: CLAS standards	12/2024	CCO offers continuing education to CHWs on all the following topics for priority populations: Social Determinants of Health, Social Needs Screenings	07/2025
Monitoring measure 2.2	Distribute member materials and track delivery			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Materials and resources developed for targeted populations including COFA and HOP members	Track the channels and methods in which materials and resources (e.g., written brochures) that meet cultural and linguistic standards to inform identified priority populations of CHW services are delivered and used;	12/2024	Utilize CHWs to help develop and distribute co-branded resources with clinics, CBOs, and/or community partners who work with and serve identified priority populations.	12/2025

	this will inform effectiveness and accessibility of materials			

Project 94: Technical Assistance for PCPCHs

A. Project title: Technical Assistance for PCPCHs

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

If continued, insert unique project ID from OHA: 94

B. Components addressed

1. Component 1: PCPCH: Member enrollment
2. Component 2 (if applicable): PCPCH: Tier advancement
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** EOCCO progressed in some activities in the past year and saw less movement in other activities. For newly enrolled members who do not select a primary care provider (PCP) within their first 90 days of enrollment, EOCCO's Provider Relations staff continued the policy of assigning members to the highest-tiered in-network PCPCH clinic in the county where the member resides. If more than one such option exists, the members are assigned to the closest clinic by distance. This ensures that geographically convenient PCPCH clinics are prioritized when assigning members to PCPs. Despite continuing this policy, EOCCO saw a decrease in membership assigned to Tier 4 clinics from 60.8% in 2023 to 58.8% 2024. Conversely, the percent of members assigned to sites without PCPCH certification increased from 7.5% in 2023 to 9.3% in 2024.
   EOCCO recognizes the significance that REALD-SOGI data yields when evaluating specific populations for health disparities, however, the project team ultimately chose not to stratify member assignment to PCPCH sites using REALD or GI categories because the only individual criteria used when assigning members to PCPCH sites is age. The Provider Relations staff uses member age to determine which members should be assigned to pediatric practices vs. all-ages family practices vs. adults-only practices. This decision was approved by OHA.

   Because the decision to select a PCPCH-certified clinic is largely made by the CCO rather than the member, the project team also chose to shift focus away from a specific member education campaign outlining the benefits of visiting a PCPCH site to more general content on the value of a PCP relationship. The CCO is still addressing increasing PCP utilization in general and instead chose to work with its internal Marketing team and external marketing contractors to create region-specific and culturally relevant videos on the importance of visiting one's PCP and what to expect at those visits in 2023. These videos will be promoted via the CCO website and social media channels later in 2024.

   EOCCO's Clinical Consultant was able to provide proactive PCPCH Technical Assistance (TA) on behavioral health integration (BHI) to one Tier 4 clinic in 2023 (Asher Community Health Center). This site did not ultimately advance tiers in 2023, largely due to challenges with behavioral health provider staffing, but did maintain their Tier 4 PCPCH certification. The Clinical Consultant did not pursue tier advancement discussions with the three organizations mentioned in the 2023 submission (Strawberry Wilderness Community Clinic, Valley Family Health Care, and Grande Ronde Hospital Clinics). These sites did maintain their Tier 4 status, which allowed over 17,000 EOCCO members to continue receiving care from Tier 4 clinics.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   - Monitoring measure 1.1: EOCCO did not achieve the target of increasing membership assigned to Tier 5 clinics from 23.0% in 2023 to 25.0% by January 2024. As of February 2024, 23.2% of membership is

assigned to a Tier 5 clinic. This is primarily due to two contracted PCPCH sites (Harrison Family Medicine and Gorge NP Partners) losing their PCPCH certification in 2023.
    - However, it is worth noting that the project team chose to refine which EOCCO members were included in these calculations in 2024 by only including members with physical health benefits (CCO-A and CCO-B) rather than all CCO types. This means that the numbers aren't directly comparable between the 2023 and 2024 submissions.
- Monitoring measure 1.2: The target and benchmark to stratify PCPCH clinic members by REALD and SOGI categories were not achieved due to shift in focus on this project. The project team ultimately chose not to perform this analysis because the CCO does not use individual criteria when assigning members to PCPCH sites. This measure will be removed for the 2024 submission.
- Monitoring measure 1.3: EOCCO did not achieve the target of completing draft PCPCH member education materials by January 2024 because the project team chose to capitalize on the parallel PCP utilization video project instead. This measure will be removed for the 2024 submission.
- Monitoring measure 2.1: The CCO did not meet its target of advancing at least one site from Tier 4 to 5 in 2023 due to staffing turnover and competing priorities around the Medicaid redetermination process at the three organizations mentioned in the 2023 submission.

3. **Lessons learned over the last year:**
EOCCO has learned several lessons about PCPCH member enrollment and tier advancement in the past year. The first is that many PCPCH sites may have reached the tier that is appropriate for them at this time given the services they are able to provide, so tier advancement may slow in the coming years.

   The project team has also determined, through conversations with contracted providers and consumer groups such as local community health partnerships (LCHPs) that general public knowledge of the PCPCH system and the benefits of visiting a PCPCH certified site is limited, so it may not make sense to aim to increase PCPCH attribution through member education. Given the CCO's extremely rural and frontier service area, members living in many parts of the Eastern Oregon service area do not have many choices when it comes to selecting a PCP near them. As such, EOCCO will instead continue to implement internal strategies and provide clinic-level rather than member-level technical assistance to increase PCPCH member assignment.

D. Brief narrative description

1. **Project population:**
The population for this project is all EOCCO members with physical health benefits (CCO-A and CCO-B). CCO 2.0 requirements indicate that all Oregon Medicaid CCO members must be assigned to a primary care provider or clinic.

2. **Intervention (address each component attached):**
The CCO will continue the two intervention activities outlined in the 2023 submission to meet the goals of increasing the number of members assigned to PCPCH clinics and advancing PCPCH tiers for lower-tier clinics. The project team has made some changes to the associated monitoring measures and activity details in order to align with the increased focus on clinic-level interventions rather than member-level interventions.
EOCCO will continue the activity of prioritizing member assignment to PCPCH-certified clinics by utilizing the internal member assignment policy mentioned in section C.1. This involves the EOCCO Provider Relations team performing a monthly review of newly assigned members who have not yet selected their own PCP and using data-informed processes to select the most appropriate provider by PCPCH status, member age, and member geography.

   EOCCO will also continue the TA intervention for contracted clinics. The Clinical Consultant will continue working with clinics who have opportunities for tier advancement and supporting targeted interventions to improve their PCPCH tiers. This technical assistance will be on a direct one-on-one basis with the clinics, providing highly

tailored support. The Clinical Consultant and project team will also make use of EOCCO's existing Behavioral Health Integration (BHI) contract to encourage BHI-contracted sites who have not yet achieved Tier 5 certification to work toward that level. This group of clinics was selected because many of them have demonstrated through quarterly BHI reporting that they have sufficient clinical structures in place to eventually attest to meeting the measures under PCPCH standard 3.C 'Behavioral Health Services'.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: By January 2026, EOCCO will increase the percentage of members with CCO-A or CCO-B plans who are assigned to a Tier 5 PCPCH clinic to 26.2% by utilizing its internal member assignment policy to prioritize member assignment to geographically-appropriate PCPCH certified clinics.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Percentage of currently enrolled CCO-A or CCO-B members who are assigned to a PCPCH-certified clinic. Measured using a combination of monthly PCPCH status reports and monthly member enrollment rosters.			
Baseline or current state (02/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No certification: 9.3% Tier 3: 8.7% Tier 4: 58.8% Tier 5: 23.2%	No certification: 8.9% Tier 3: 9.1% Tier 4: 58.8% Tier 5: 23.2%	01/2025	No certification: 8.9% Tier 3: 9.1% Tier 4: 55.8% Tier 5: 26.2%	01/2026

Activity 2 description: By January 2026, EOCCO will increase the percentage of contracted primary care clinics with Tier 5 PCPCH certification to 15.3% by providing technical assistance to clinics with opportunities for tier advancement. The project team will also increase the percentage of contracted BHI organizations with Tier 5 status to 37.5% by providing tailored support to BHI-contracted sites with the potential to advance to Tier 5.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percentage of contracted primary care clinics with Tier 5 PCPCH status. Measured using monthly PCPCH status reports.			
Baseline or current state (02/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No certification: 36.5% Tier 3: 11.8% Tier 4: 37.6% Tier 5: 14.1%	No certification: 35.3% Tier 3: 13.0% Tier 4: 37.6% Tier 5: 14.1%	01/2025	No certification: 35.3% Tier 3: 13.0% Tier 4: 36.5% Tier 5: 15.2%	01/2026
Monitoring measure 2.2	Percentage of contracted primary care clinics who also signed EOCCO's BHI contract with Tier 5 PCPCH status. Measured using monthly PCPCH status reports.			
Baseline or current state (02/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Tier 4: 75.0% Tier 5: 25.0%	Tier 4: 75.0% Tier 5: 25.0% *At least one Tier 4 BHI site will have started the process of applying for Tier 5 status.*	01/2025	Tier 4: 62.5% Tier 5: 37.5%	01/2026

Project 423: Expansion of BHI Using THWs and HIT

A. Project title: Expansion of BHI Using THWs and HIT

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

If continued, insert unique project ID from OHA: 423

B. Components addressed

1. Component 1: Behavioral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   As of 2024, EOCCO has renewed contracts with ten Patient-Centered Primary Care Home (PCPCH) clinics for behavioral health integration (BHI). While the TQS project from the previous year focused on onboarding all PCPCH clinics with BHI contracts onto the Unite Us [Connect Oregon] Community Information Exchange (CIE) tool, EOCCO has realigned benchmarks and milestones to prioritize integrating Traditional Health Workers (THWs) into Unite Us to support PCPCH care delivery. This underscores EOCCO's commitment to innovative use of THWs and Health Information Technology (HIT) within BHI PCPCH clinics, enhancing members' access to comprehensive, coordinated, behavioral health services. These initiatives aim to address chronic understaffing and under-resourcing of behavioral health services in Eastern Oregon. By integrating THWs and Unite Us into BHI clinic services and workflows, EOCCO aims to bridge current gaps in cross-sector provider communication and referral workflows improving integration models, patient access to care, and coordination of behavioral health benefits and resources across EOCCO's service area.
   Currently, EOCCO has onboarded 23 THWs onto Unite Us, including Community Health Workers, Peer Support Specialists, and Peer Wellness Specialists. These specialists bring unique expertise in navigating the behavioral health system, providing member support, and coordinating care among various service providers and community partners. Moreover, the demographic data collected from this THW workforce, including REALD information, supports EOCCO's broader efforts to understand behavioral health disparities. Recognizing that THWs often share socioeconomic, cultural, linguistic, and lived experiences with members, EOCCO emphasizes the importance of expanding and integrating THWs to meet the evolving needs of its diverse member base.[1]

   Below is a summary of the current demographics for onboarded Unite Us THWs, as well as the broader THW workforce as collected through quarterly CCO-led THW Utilization reporting. Compared to the THW workforce, a greater proportion of THWs on Unite Us identify as Hispanic/Latino/Latinx [THW workforce=18 (7.79%, excluding unknowns 13.4%), THWs on Unite Us=5 (21.74%)] and list Spanish as their preferred spoken language [THW workforce=19 (8.23%, excluding unknowns 13.29%), THWs on Unite Us=4 (17.39%)]. While EOCCO acknowledges that deriving meaning from THW workforce REALD analyses is limited due to small sample size and a large proportion of unknown/undisclosed data (see Project 423: Table 4 and Table 5 for more detail) they serve as important indicators for the cultural and linguistic concordance of EOCCO's THW workforce.

   EOCCO remains committed to ongoing collection of REALD data in partnership with THWs to fill current information gaps and will integrate SOGI data collection strategies. Moving forward, EOCCO plans to include

[1] US Department of Health and Human Services (2021). "On the Front Lines of Health Equity: Community Health Workers". *Centers for Medicare & Medicaid Services*, 1-17. https://www.cms.gov/files/document/community-health-worker.pdf.

SOGI questions in EOCCO's annual THW demographic survey and the quarterly THW utilization reports and will provide THW-focused training on SOGI data collection strategies.

To address health disparities and access gaps within PCPCH BHI clinics, EOCCO plans to initiate a REALD and SOGI analysis of behavioral health service utilization among members assigned to contracted PCPCH BHI clinics. Current 834 enrollment file and OHA REALD-SOGI Repository data indicates that, compared to the EOCCO member population as a whole, a greater proportion of members assigned to PCPCH BHI clinics identify as Hispanic/Latino/Latinx [EOCCO total population=18,644 (24.88%), PCPCH BHI assigned=13,046 (34.33%)] and list Spanish as their preferred spoken language [EOCCO total population=11,851 (15.82%), PCPCH BHI assigned=9,284 (24.43%)] (see Project 423: Table 1 and Table 3 for full analysis). By comparing assigned PCPCH BHI clinic member REALD and GI data to BHI service utilization trends, EOCCO strives to identify care access barriers or inequities across BHI clinics in future project years.

Although limited GI data for EOCCO's membership exists at this time, EOCCO will continue the work of collecting and integrating GI data when available to allow for meaningful comparison of GI variables between member groups/populations. Once sexual orientation (SO) data is made available through the OHA Repository, EOCCO will incorporate these fields into its existing demographic file and internal Data Warehouse (see Project 91 for additional information about this process). Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to identify disparities. Once disparities are identified, the CCO will examine potential root causes for these inequities and revise or create interventions to address these causes.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   - Monitoring Measure 1.1: Over the past year, EOCCO advanced in meeting set targets and benchmarks for Activity 1. Initially aiming for 75% of BHI clinics to be onboarded onto Unite Us by December 2023, only ten of the previously eleven BHI PCPCH clinics renewed their contracts for behavioral health service integration and 70% were successfully onboarded onto Unite Us. The loss of a contracted BHI clinic, coupled with the remaining clinics choosing to delay Unite Us integration until network expansion into neighboring states (WA and ID), made achieving EOCCO's benchmark goal of 100% Unite Us platform onboarding unlikely. Responding to this, EOCCO is shifting Activity 1's focus from onboarding clinics to onboarding individual THWs from BHI clinics onto Unite Us. It is anticipated that onboarding individual THWs to the platform will be easier and more streamlined than onboarding at the clinic level and will ultimately expand behavioral health (BH) service coordination and encourage THW utilization for BHI patients. This strategic move is expected to broaden Unite Us adoption across various BH settings, enhancing social need resource access and care access for BH patients and clinics.
   - Monitoring Measure 2.1: EOCCO did not achieve Activity 2's short-term goal of assessing BHI service access by REALD and GI categories within Wallowa County by 12/2023. Internal staff turnover left EOCCO with an open Traditional Health Worker Liaison role for a majority of 2023. As the THW Liaison was staff lead for this project, project work paused during that time. Upon hire of EOCCO's new THW Liaison it was decided that Activity 2 should be refocused and expanded for clarity and impact. Shifting Activity 2 will enable a more standardized analytic procedure for assessing BHI service utilization by REALD and SOGI variables across PCPCH BHI clinics, providing richer data for care disparity analysis.

3. **Lessons learned over the last year:**
   Over the last year, EOCCO learned valuable lessons which shaped this TQS project and led to the revision of project activities to better meet the needs of EOCCO members and contracted PCPCH BHI clinic, as well as improve REALD and GI analytic strategies. EOCCO encountered Unite Us onboarding challenges with PCPCH BHI clinics located in WA and ID border counties. These clinics expressed hesitancy to onboard onto Unite Us due to the Unite Us network being limited in WA and ID, preventing referrals to services or resources in states where EOCCO members often access care. To address this barrier and continue onboarding behavioral health providers while expanding the Unite Us network, EOCCO decided to focus on integrating THW providers into the

behavioral health network and onboarding them to Unite Us. This will allow for expanded behavioral health service coordination and access across EOCCO's 12-county service area and further opportunity for referral data collection/platform utilization analysis. Additionally, EOCCO recognized the information gaps that could result from analyzing member REALD and SOGI data at a county level. Pivoting to clinic-level analysis will allow EOCCO to better understand BHI service utilization, identify any access disparities, and improve integrated care for members. EOCCO looks forward to reporting on these changes in the next TQS report.

D. Brief narrative description

1. **Project population:**
   The project population encompasses members served by PCPCH BHI clinics within EOCCO's service area, with a dual focus on understanding BHI service utilization and care access among members and expanding the BHI workforce and care coordination through onboarding of Traditional Health Workers (THWs) to the Unite Us platform. EOCCO seeks to unveil patterns in BHI service utilization and possible care disparities among patients assigned to BHI PCPCH clinics (see Project 423: Table 3 for member detail), taking into account factors such as REALD and GI data. Alongside this, EOCCO is actively working to integrate THWs into the Unite Us network, aiming to enhance access to comprehensive behavioral health services or resources for members.

2. **Intervention (address each component attached):**
   EOCCO will capitalize on the achievements of the previous year, leveraging its successful integration of Unite Us into BHI clinical settings to expand and integrate THWs involved in BH work into Unite Us. By the end of 2023, EOCCO had renewed BHI contracts with ten PCPCH clinics, extending behavioral health services to cover 50.7% of its member base. The collaboration with Unite Us will enable a seamless referral system between THW providers and community-based organizations spanning all 12 service-area counties. This integration will facilitate the provision of comprehensive care, addressing members' physical, social, oral, and behavioral health needs. Building on this foundation, EOCCO remains committed to supporting BHI clinics in optimizing their workflows, ensuring that Unite Us becomes an integral part of their operations through the support and utilization of THWs. By providing ongoing technical assistance, guidance, and training opportunities EOCCO aims to foster effective BH provider collaboration and service delivery, ultimately improving the health outcomes of members. Additionally, by conducting analyses of BHI service utilization across all PCPCH BHI clinics by REALD and SOGI variables, EOCCO is laying the groundwork for developing evidence-based and equity-driven interventions to address care disparities and enhance behavioral health service access.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: By December 2025, EOCCO will facilitate integrating Unite Us into THW workflows for THWs who work in BHI clinical settings. The number of THWs onboarded to Unite Us will increase by 100% and the CCO will host at least six unite Us trainings or TA sessions for PCPCH BHI THWs and clinic staff. EOCCO will accomplish this by:

- Leveraging relationships with BHI clinics and THWs to check platform onboarding and platform utilization statuses for THWs.
- Facilitating onboarding meetings between THWs and Unite Us team members to co-develop referral workflows.
- Providing Unite Us technical assistance (TA) and training opportunities (including navigating the Unite Us network via resource/service identification, pulling and using Unite Us data insights, and network best practices) to THWs seeking support and prioritizing content in monthly THW Collaborative meetings and clinic visits.
- Working with Unite Us to develop individualized TA sessions/trainings for interested PCPBH BHI clinics that provide live detailed demonstrations of Unite Us functionality and are tailored to each clinic's platform utilization goals and THW referral processes/workflows.
- Continuing work of integrating Unite Us across EOCCO's 12-county service area, supporting onboarding of different organization types including Social Determinants of Health (SDoH) service providers and CMHPs to enhance cross-sector behavioral health integration and build a robust network of care providers.

- Continuing work of supporting behavioral/mental health continuing education for THWs

☒ Short term or ☒ Long term

Monitoring measure 1.1	Onboard THWs onto Unite Us CIE tools and integrate CIE into THW workflows.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
23 THWs onboarded	50% increase in THWs onboarded (35)	12/2024	100% increase in THWs onboarded (46)	12/2025
No established THW referral using CIE workflows within PCPCH BHI clinics	One unique THW referral using CIE workflow developed	12/2024	Three unique THW referral using CIE workflows developed	12/2025
Monitoring measure 1.2	Host trainings and TA opportunities to enhance utilization of Unite Us by THWs within the PCPCH BHI setting			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Unite Us TA session or trainings offered	Two Unite Us trainings or TA sessions provided to PCPCH BHI THWs and clinic staff	12/2024	Six Unite Us trainings or TA sessions provided to PCPCH BHI THWs and clinic staff	12/2025

Activity 2 description: By December 2025, EOCCO will evaluate 100% of the contracted BHI PCPCH clinic's BHI service utilization and assigned member populations by REALD and SOGI categories. EOCCO will work with the Analytics team to perform REALD and SOGI analysis of members assigned to BHI clinics and compare member demographic data to BHI service utilization data. This will provide comprehensive data from which to identify any existing care disparities and to develop evidence-based and equity-driven interventions to improve BH care access gaps. EOCCO will support this by:

- Pulling reports of all EOCCO members assigned to each PCPCH BHI clinic and performing REALD and SOGI analysis to identify demographic breakdown of PCPCH BHI membership.
    - Pulling a claims report of all behavioral health integrated services billed by PCPCH BHI clinics within a one-year look-back period [specific time frame dependent on date analysis conducted]. BHI services will be identified using Behavioral Health Integration Service table codes:

Behavioral Health Integration Services Tables						
90791	90839	96110	96168	98967	99441	H0004
90792	90840	96127	96170	98968	99442	H0031
90832	90846	96156	96171	99406	99443	H0032
90833	90847	96158	97129	99407	99497	T1016
90834	90853	96159	97130	99408	99498	T1023
90837	90822	96167	98966	99409	G2012	

☐ Short term or ☒ Long term

Monitoring measure 2.1	Analyze service utilization and care gaps within PCPCH BHI clinics based on REALD and SOGI categories

Baseline or current state (06/2024)	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No PCPCH BHI clinic member populations or service utilization trends analyzed	25% of BHI clinic member populations and BHI service utilization trends analyzed	12/2024	100% of BHI clinic member populations and BHI service utilization trends	12/2025

Project 505: Increasing Pediatric Dental Access through First Tooth Certification

A. Project title: Increasing Pediatric Dental Access through First Tooth Certification

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

If continued, insert unique project ID from OHA: 505

B. Components addressed

1. Component 1: Oral health integration
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):**
   In 2023 and 2024 EOCCO has continued to make dental access and utilization in the Eastern Oregon services area a priority through integrating dental care into physical and behavioral health settings. EOCCO has continued training and certifying medical staff in Eastern Oregon clinics on conducting oral health evaluations and applying fluoride varnish to children ages 1-14 during heir well child visit in order to increase childhood Dental Utilization in Umatilla County specifically and Eastern Oregon as a whole. Through partnering with Advantage Dental to provide these trainings, EOCCO has successfully trained 26 clinics and 100 medical providers in Eastern Oregon that are now able to conduct oral health evaluations and apply fluoride varnish to pediatric patients. These 100 medical providers trained practice in Umatilla, Union, Harney, Morrow, Lake, Grant, Malheur, and Baker Counties. Furthermore, First Tooth trainings have successfully increased Dental Utilization in Umatilla County by 6% since 2023 and have increased EOCCO's overall Dental Utilization rate to 67.15%. Because of the broad interest and success these trainings have gained, EOCCO will focus on increasing Dental Utilization rates across the entire Eastern Oregon service area.

   The project team also gathered information on EHR and health information exchange (HIE) tools used among its contracted dental clinics through the 2024 Health Information Technology (HIT) Roadmap and Data Reporting File. In the 2023 Roadmap, EOCCO was able to collect EHR information on dental practices for 40% of contracted dental providers. In the 2024 Roadmap, the CCO and contracted Dental Care Organizations (DCOs) were able to increase the percentage of dental practices with known EHR systems to 85% through annual provider surveys and targeted outreach. In both the 2023 and 2024 Roadmaps and Data Files, EOCCO and the DCOs had health information exchange (HIE) and community information exchange (CIE) information on 4% of contracted dental providers.

   The project team conducted REALD-GI analysis by using a member demographic file with data from both OHA 834 enrollment files and the OHA REALD-SOGI Data Repository to evaluate available race, ethnicity, language, disability, and gender identity data for EOCCO members ages 1-14: totaling 20,729 members. Findings show that EOCCO members identifying as Black, American Indian or Alaska Native, and Pacific Islander was discovered to have much lower Dental Utilization rate than their Caucasian or Hispanic counterparts. Project 505: Table 1 shows a breakdown of race congruent with their measurement year (MY) 2023 Dental Utilization Rate. In short, members identifying as American Indian or Alaska Native have a Utilization rate of 60.99%, members identifying as Black have a rate of 54.30%, and members identifying as Pacific Islander have a rate of 28.08% which is more than 38% lower than EOCCO members identifying as Caucasian. There were no significant findings around ethnicity, language, disability, or gender identity.

   ***Project 505: Table 1**. MY 2023 Dental Utilization Rates Across Racial Categories*

Race	MY 2023 Dental Utilization Rate
American Indian or Alaska Native	**60.99%**
Asian or Pacific Islander	63.01%
Black	**54.30%**
Caucasian	66.50%
Hispanic	70%
Pacific Islander	**28.08%**
Not Provided	66.77%

EOCCO recognizes the significance that REALD-SOGI data yields when evaluating this project population for health disparities. Though collecting this data poses challenges, EOCCO will continue to look for new ways to increase data completeness through an increased focus on gathering social needs and enhanced demographic data through the Accountable Health Communities (AHC) screening initiative. Please see Project 91: Improvement and Stratification of Health Equity Data for more details on REALD-SOGI data integration plans.

Once sexual orientation (SO) data is made available through the OHA Repository, EOCCO will incorporate these fields into its existing demographic file and internal Data Warehouse. Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to identify disparities. Once disparities are identified, the CCO will examine potential root causes for these inequities and revise or create interventions to address these causes.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

- Monitoring measure 1.1 - First Tooth Certification: In 2023, one of EOCCO's targets and benchmarks involved focusing on increasing First Tooth Certification in Umatilla County. Specifically, certifying Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center to conduct oral health evaluation and apply fluoride varnish during regular well child visits. Through goal analysis, it was found that all clinics, except for Yellowhawk Tribal Health Center were successfully trained in First Tooth. Because of the success of this program, EOCCO is working to expand First Tooth outside of Umatilla County and will outreach to the full Eastern Oregon service area with a specific focus on counties with fewer First Tooth-certified providers such as Wheeler, Wallowa, Union, Sherman, and Gilliam counties.
- Monitoring measure 1.2 - Cultural Competency Training and Language Access Roster: This activity was removed from this project due to lack of relevance to Oral Health Integration.
- Monitoring measure 1.3 - First Tooth integration and billing for services: First Tooth integration and billing for services is another target set by EOCCO to increase integration of oral health evaluations and fluoride varnish application in medical clinics. In 2023, Good Shepherd Medical Center, Pediatric Specialist of Pendleton, Yakima Valley Farm Workers Clinic, and Yellowhawk Tribal Health Center did not conduct oral health evaluations or apply fluoride varnish and, therefore, did not bill for services. This year, every clinic targeted except for Yellowhawk Tribal Health Center is not only certified but has actively implemented oral health evaluations and fluoride varnish into their regular well child visits and billing practices.
- Monitoring measure 1.4 - Dental Utilization: In 2023, EOCCO implemented a target to increase Dental Utilization in Umatilla County by 1.5% by 12/2025, totaling a 59.2% utilization rate. Umatilla County's final 2023 Dental Utilization rate increased by over 6% to 65.8% for EOCCO members ages 1-14. EOCCO has surpassed its target and will now work to increase Dental Utilization in all Eastern Oregon counties (see Project 505: Table 2 for all county-level rates).
- Monitoring measures 2.1 & 2.2 - Member Education and Grievance and Appeals System Change & Dental Access: These activities were discontinued due to OHA's removal of the Grievance and Appeal System TQS Component.

- Monitoring measure 3.1 - Data sharing between oral and physical health: EOCCO set a target to increase data sharing between oral and physical health providers. This target included conducting an assessment across Umatilla County to determine current EHR capabilities between oral and physical health providers via survey and/or scheduled meetings. Additionally, EOCCO strived to bring discussion to incentive measure workgroup meetings to explore potential solutions with the DCOs. Currently, through HIT investigation, 85% of contracted dental providers use an EHR system that is known to the CCO/DCOs. Because of this, EOCCO is scheduled to reach its long-term target of data sharing between oral and physical health organizations. However, further research is needed.

Several of EOCCO's activities and monitoring measures were discontinued due to staff turnover, lack of relevance to the Oral Health Integration goals, and OHA's removal of the Grievance and Appeal System TQS Component. Because EOCCO is no longer working on these programs, the activities and monitoring for performance improvement in this year's report has been updated to reflect relevant changes, and new goals have been created for 2024 that will continue to work to increase dental access and utilization in Eastern Oregon.

3. **Lessons learned over the last year:**
Over the last year, it became clear that oral health evaluation training for clinics is not a one-time event. With staff turnover in clinics, changes in Medicaid policy and in fluoride varnish billing codes, clinics often need to have two or more training courses throughout the year and to be confident in conducting oral evaluations and fluoride applications, as well as billing for services. Because of this, checking in quarterly with trained clinics in EOCCO's service area was integrated into the workflow to monitor medical provider's confidence with the material and to gauge the need for another training. For each "refresher" training conducted, a dental hygienist with Advantage Dental would be scheduled to meet with clinics and to discuss topics geared specifically towards each clinic's needs. In terms of increasing data sharing between physical and oral health providers, the project team has found that HIE adoption rates continue to be low within the dental industry as this type of tool is new in this sector, aside from the use of Point Click Care in some clinics and at some DCOs. Further information about the different platforms available and their benefits and use cases for dental providers is needed to help educate and promote HIE use among our providers.

D. Brief narrative description

1. **Project population:**
The target population of the project is EOCCO members ages 1-14 residing across Eastern Oregon's service area. Additional attention will be paid to EOCCO members ages 1-14 residing in Harney County, and EOCCO members who identify as American Indian or Alaska Native, Black, or Pacific Islander. Currently the overall Dental Utilization in the Eastern Oregon service area is 67.15%. The rate among EOCCO members ages 1-14 residing in Harney County is 59.14%. Furthermore, EOCCO members identifying as American Indian or Alaska Native have a rate of 60.99%, members identifying as Black have a rate of 54.30%, and members identifying as Pacific Islander have a rate of 28.08%. This clear disparity helps us pinpoint focus areas to increase Dental Utilization and dental access in general.

2. **Intervention (address each component attached):**

Activity 1:

- Increasing Dental Utilization through First Tooth Certifications: The Dental Utilization metric measures all oral health services rendered for EOCCO members ages 1-14, rather than just preventive services (D1000-D1999). Monitoring dental utilization in the Eastern Oregon service areas will help indicate access and availability of dental services to Eastern Oregon residents and help track if oral health interventions are successful among each Eastern Oregon county. Through interventions such as First Tooth Certification, integrating oral health into well child visits, partnering with community

organizations, and data sharing between oral and physical health clinics, EOCCO will work to increase Dental Utilization rates among EOCCO members ages 1-14 with specific attention to members identifying as American Indian or Alaska Native, Black, and Pacific Islander, and to members residing in Harney County.

- First Tooth integration and billing for services: First Tooth training and certification is a prioritized intervention used to address EOCCO's target population for oral health integration. The certification training is a 1-hour live virtual session hosted by a dental hygienist from Advantage Dental. Topics covered during the training include the prevalence and impact of oral disease, prevention, risk assessment, fluoride varnish application, implementation, workflow tips, billing, and access to dental care and a dental home. By the conclusion of the training, providers will be able to conduct an oral health evaluation (D0191) and providers, physician assistants, nurses, and medical assistants will be able to apply fluoride varnish (CPT 99188) during a well child visit and bill for those services.
    - The CCO also aims to certify clinics in each of our 12 counties, so at least one site in Wheeler, Wallowa, Union, Sherman, and Gilliam counties will be recruited to be First Tooth Certified.
    - Advantage Dental will also continue to be available to clinics for technical assistance while they are implementing the First Tooth curriculum into their workflows. Furthermore, if clinics would like to be re-trained due to staff turnover, changes in policy, and/or billing, Advantage will offer Biannual "refresher" trainings available for any clinician to register for. As a part of these trainings, EOCCO representatives will also present Dental Utilization data broken out by REALD-SOGI categories and workshop with clinics on how to target prioritized populations.

Activity 2:

- Tracking use of EHR systems in dental practices: Further research must be completed to determine the dental and PCP offices' electronic health records (EHR) capabilities to share member information. In the meantime, to open pathways for sharing member health information between dentists and PCPs, the EOCCO will provide a monthly gap list to participating clinics indicating which patients ages 1-14 have not had preventive oral health services anytime during the calendar year to allow physical health clinics to conduct outreach attempts.
- Tracking use of HIE/CIE in dental practices: During the annual HIT Roadmap and Data Reporting File project, EOCCO and the DCOs work to learn more about HIE, and CIE capabilities of contracted providers. In 2024, EOCCO will continue working with Dental Care Organizations to use this data to provide education on the value of HIE and CIE systems for dental practices.

E. **Activities and monitoring for performance improvement (duplicate until all activities and measures are included)**

Activity 1 description: EOCCO, in partnership with Advantage Dental, will continue to certify clinics in First Tooth in the Eastern Oregon Service area to conduct oral health evaluations (D0191) and apply fluoride varnish (CPT 99188) as needed during a well child visit. The goal is to increase childhood Dental Utilization by 12/2028 by 3.0% across all counties and by 2.0% for members who indicated their primary race as American Indian or Alaska Native, Black, or Pacific Islander. The American Indian or Alaska Native, Black, and Pacific Islander populations will be addressed through partnership with culturally-specific community partners in Eastern Oregon such Yellowhawk Tribal Health Center and the Burns Paiute Tribe for our AI/AN members and the Micronesian Islander Community (MIC) for our Pacific Islander members. The project team will also work to identify group(s) that serve Black individuals in Eastern Oregon and will establish a relationship.

The CCO will also aim to provide First Tooth trainings to staff in at least three clinics in each of the 12 Eastern Oregon counties by 12/2028. EOCCO and Advantage will give clinics the option of a 1-on-1 training or a Bi-annual "Lunch and Learn" training where clinics can opt in or out of a training based on their need. These trainings will include presentations on Dental Utilization rates stratified by REALD-SOGI categories with the intent of educating providers on dental care disparities faced by certain populations and ultimately discussing ways to reach prioritized populations.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Dental Utilization for EOCCO members across all 12 counties, as determined by claims data			
Baseline or current state (12/2023)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
67.15% of members have used dental services	68.65% (increase by 1.5%)	12/2026	70.15% (increase by 3%)	12/2028
Monitoring measure 1.2	Dental Utilization for all EOCCO members identifying as American Indian or Alaska Native (AI/AN), Black, or Pacific Islander, as determined by claims data			
Baseline or current state (12/2023)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
60.99% of members identifying as AI/AN have used dental services	61.99% of members identifying as AI/AN have used dental services and EOCCO will engage with culturally-specific partners to discuss Dental Utilization disparities.	12/2026	62.99% of members identifying as AI/AN have used dental services and targeted outreach will be made to members identifying as AI/AN	12/2028
54.30% of members identifying as Black have used dental services	55.30% of members identifying as Black have used dental services and EOCCO will engage with culturally-specific partners to discuss Dental Utilization disparities.	12/2026	56.30% of members identifying as Black have used dental services and targeted outreach will be made to members identifying as Black	12/2028
28.08% of members identifying as Pacific Islander have used dental services	29.30% of members identifying as Pacific Islander have used dental services and EOCCO will engage with culturally-specific partners to discuss Dental Utilization disparities.	12/2026	30.30% of members identifying as Pacific Islander have used dental services and targeted outreach will be made to members identifying as Pacific Islander	12/2028
Monitoring measure 1.3	First Tooth integration and billing for services, as determined through Advantage Dental trainings and claims data			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
At least 1 clinic in Umatilla, Union, Harney, Morrow, Lake, Grant, Malheur, and Baker counties has been First Tooth trained and is successfully	At least 1 clinic in Wheeler, Wallowa, Union, Sherman, and Gilliam counties has been First Tooth trained and is successfully conducting oral health evaluations and applying	12/2026	All Eastern Oregon counties will have 3 or more clinics that are First Tooth trained and are successfully conducting oral health evaluations and applying fluoride	12/2028

conducting oral health evaluations and applying fluoride varnish and billing for services	fluoride varnish and billing for services		varnish and billing for services. If a county has fewer than 3 clinics in total, all clinics should meet these criteria.	
Monitoring measure 1.4	Presentation of REALD-SOGI-stratified Dental Utilization data at biannual First Tooth Refresher Trainings			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
REALD-SOGI-stratified Dental Utilization data has not been shared with providers	EOCCO staff will present REALD-SOGI-stratified Dental Utilization data during biannual First Tooth trainings	12/2025	All First Tooth clinics will be aware of trends in REALD-SOGI-stratified Dental Utilization data and will incorporate it into their practice	12/2027

Activity 2 description: By December 2025, further research will be completed to determine the dental and PCP offices' electronic health records (EHR) capabilities to share member information between each discipline. The CCO and DCOs gather EHR, HIE, and CIE information on contracted providers through the annual HIT Roadmap and Data Reporting File projects. The project team will continue leveraging these data collection efforts to increase the number of known dental EHR systems. Once the project team is confident that the vast majority of dental sites have EHR systems in place, the CCO and DCOs will focus on providing education on the value of HIE and CIE systems for dental practices.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Use of EHR systems in dental practices, as determined through HIT Data Reporting File.			
Baseline or current state (03/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
85% of contracted dental providers use an EHR system that is known to the CCO/DCOs	90% of contracted dental providers use an EHR system that is known to the CCO/DCOs	03/2025	100% of contracted dental providers use an EHR system that is known to the CCO/DCOs	03/2026
Monitoring measure 2.2 (03/2024)	Use of HIE/CIE systems in dental practices, as determined through HIT Data Reporting File.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
4% of contracted dental providers use an HIE or CIE system that is known to the CCO/DCOs	14% of contracted dental providers use an HIE or CIE system that is known to the CCO/DCOs	03/2026	28% of contracted dental providers use an HIE or CIE system that is known to the CCO/DCOs	03/2027

Project 506: Improving Health Outcomes of Full Benefit Dual Eligible (FBDE) Members with Chronic Kidney Disease

A. Project title: Improving Health Outcomes of Full Benefit Dual Eligible (FBDE) Members with Chronic Kidney Disease

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

If continued, insert unique project ID from OHA: 506

B. Components addressed

1. Component 1: SHCN: Full benefit dual eligible
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** Summit Health and EOCCO made progress on this project and associated activities in the past year. The project team received buy-in from the EOCCO and Summit Health Clinical Advisory Panels, Government Programs Medical Director, and Stars Oversight and Advancement Responsibility (SOAR) Committee. These groups will have continued oversight on the workflows and progress of the target population to ensure dual-enrolled EOCCO-Summit Health members are receiving quality care from both lines of business. In the past year, the EOCCO-Summit Quality team contacted engaged primary care clinics to introduce them to a Strive Health representative who offered providers learning sessions and engaged them in the case management process. Providers were given educational materials and sample workflows on how their patients may engage with Strive Health.

   There are currently two FBDE members enrolled in Strive Health's Kidney Hero program, which comprises 40% of the eligible member population. Throughout 2023 FBDE members ages 18 and up with chronic kidney disease (CKD) or end-stage renal disease (ESRD) were connected to Strive Health via provider referral, Summit Health Case Manager referral, member mailings resulting in a self-referral, and/or direct phone outreach from Strive. Strive Case Managers did not create or maintain care plans for either of these members, so the project team does not have access to the data points outlined in Activities 1 and 2 in the 2023 submission. Summit Health and EOCCO were able to onboard five Strive Health Case Managers to the Unite Us Community Information Exchange (CIE) platform to facilitate referrals to resources outside of the medical scope.

   It is not possible to perform meaningful analysis on REALD-GI disparities in this project population given the small number of FBDE members enrolled in the Strive program. Instead, the project team chose to review REALD-GI data from the OHA 834 enrollment files and the OHA REALD-SOGI Data Repository for all 101 dual-enrolled members on SHCN plans (FBDE-SHCN) in order to determine what disparities program participants *may* be facing. This analysis revealed that FBDE-SHCN members have a significantly higher prevalence of functional limitations and/or disability flags than the comparison populations, as demonstrated in Project 506: Table 1.

Project 506: Table 1. *Functional Limitation and Disability Flags Across FBDE-SHCN, EOCCO-SHCN, and Strive-Enrolled EOCCO Member Populations*

Functional Limitation & Disability Flags	% of FBDE-SHCN Members with Flag *(n=101)*	% of Strive-Enrolled EOCCO (non-dual) Members with Flag *(n=86)*	% of All EOCCO (non-dual) SHCN Members with Flag *(n=32,967)*
Blindness	19.8%	12.8%	6.2%
Deafness	**22.8%**	2.3%	5.3%
Walking	59.4%	26.7%	12.0%
Dressing	**32.7%**	9.3%	6.0%
Errands	42.6%	15.1%	11.3%
Memory	**44.6%**	12.8%	15.7%
Limited Activity	30.7%	14.0%	11.1%

Most notably, the prevalence of individuals who experience deafness, have difficulty dressing, and have memory limitations are at least three times higher in the FBDE-SHCN population than both the Strive-enrolled EOCCO (non-dual) members and the full population of EOCCO members on SHCN plans. This could be due to the higher average age of the FBDE-SHCN population, which is 66.4 years compared to 54.8 and 33.0 for the other groups respectively. However, it is unlikely that the large discrepancy in limitation and disability flags can be fully attributed to the higher average age of the FBDE-SHCN group and warrants further intervention and support for individuals with those disabilities and limitations.

The project team conducted further REALD-GI analysis and stratified available race, ethnicity, and language data for the FBDE-SHCN members. The team ultimately found that the project population roughly aligned with the overall Strive-enrolled EOCCO and EOCCO-SHCN member populations in race, ethnicity, and language categories. There was no gender identity data provided for FBDE-SHCN members in OHA's REALD-SOGI Data Repository file, so GI analysis was not performed for this project.

EOCCO-Summit recognizes the significance that REALD-SOGI data yields when evaluating this project population for health disparities. Though collecting this data poses challenges, the project team will continue to look for new ways to increase data completeness through an increased focus on gathering social needs and enhanced demographic data through the Accountable Health Communities (AHC) screening initiative. Please see Project 91: Improvement and Stratification of Health Equity Data for more details on REALD-SOGI data integration plans. In the meantime, EOCCO-Summit has incorporated data from OHA's REALD-SOGI Data Repository file into an existing member demographic data file for use in the 2024 TQS and other member-level projects.

Once sexual orientation (SO) data is made available through the OHA Repository, the project team will incorporate these fields into its existing demographic file and internal Data Warehouse (see Project 91 for additional information about this process). Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to identify disparities. Once disparities are identified, EOCCO-Summit will examine potential root causes for these inequities and revise or create interventions to address these causes.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   - Monitoring Measures 1.1, 2.1, 2.2, & 2.3: The FBDE members enrolled in Strive Health did not have care plans recorded, so the project team did not have access to the hypertension and diabetes data outlined in last year's project submission. Consequently, these targets and benchmarks were not met. These activities and measures will remain in place in hopes that FBDE enrollment in Strive and care plan documentation will increase in future years.

- Monitoring Measure 2.4: This project met the target of at least 75% of members enrolled in Strive Health *not* progressing in their disease state by 12/2023. As of this report, 100% of members had *not* progressed in their disease state. This measure will be reported inversely moving forward as the percentage of members who progressed in their disease.
- Monitoring Measure 3.1: The health plans did not achieve the target (requesting the addition of functional limitations and/or disability flags to the Strive Health eligibility file) or benchmark (ensuring that the Analytics team incorporated these flags into the file) since the last TQS submission. This was due to staffing turnover on both the TQS project and Analytics team. Both teams are now fully staffed and attention will be redirected to completing this task in the coming year.

3. **Lessons learned over the last year:**
Because the Strive Health initiative was relatively new at the time of the previous TQS submission, the project team has learned a great deal about working and coordinating care with this case management vendor during this time. FBDE member enrollment in the Kidney Hero program was not as high as expected (n=2), however given the small number of eligible members with CKD (n=5) and relatively small population of FBDE members as a whole (n=181) this enrollment number is not seen as a poor outcome. Staff at both Strive Health and EOCCO-Summit found it challenging to notify providers regarding which of their members are eligible for Strive's kidney programs. The project team ultimately found it more effective for the health plans to send initial communications to providers on this program via mail and fax rather than having Strive staff "cold-call" clinics.

Another challenge with this project over the past year has been limited engagement with the Unite Us platform by the five Strive Health Case Managers that were granted access to the tool. This has made it difficult for the Strive team to effectively address social factors impacting members' health, which will be addressed through new intervention Activity 4, described below.

D. Brief narrative description

1. **Project population:**
The focus population for this project is full benefit dual eligible (FBDE) Summit Health and EOCCO members ages 18 and up with CKD or ESRD diagnoses who are eligible for and have enrolled in the Strive Health Kidney Hero program. The focus subgroup will be individuals in this group with functional limitations and/or disabilities, as defined in the OHA 834 enrollment files.

2. **Intervention (address each component attached):**
The project team will continue the two intervention activities outlined in the 2023 submission and has added one new intervention to better address upstream determinants of health outcomes for members with CKD. All activity progress and monitoring measures will be shared with the Summit Health Clinical Advisory Panel (CAP) and Stars Oversight and Advancement Responsibility (SOAR) committees for continued oversight on the workflows and progress to ensure dual-enrolled EOCCO-Summit Health members with SHCN are receiving quality care from both lines of business.
    - Continued Intervention: Strive Health will create and maintain care plans alongside the members every 8-9 weeks and will share these plans with member's PCP, insurer, and any other provider/specialist that is required for quality care. Care plans will include clinical data points such as A1c levels, and blood pressure screenings as well as non-clinical documentation on services such as social determinants of health screenings and mental health support. The EOCCO and Summit Analytics department will continue reporting on disease state progression for Strive-enrolled members in order to track health outcomes for program participants.
    - Continued Intervention: The project team will continue working with the health plan Analytics team to integrate functional limitations and/or disability flags to the Strive Health eligibility file to assist the Strive team in conducting appropriate outreach and referrals for all members.

- New Intervention: The project team will collaborate with Strive Case Managers to provide them resources to better address social determinants of health impacting members' health outcomes. This will be done by providing additional training on the Unite Us CIE tool and sharing the Eastern Oregon Community Resource Guide. Due to the high prevalence of individuals with "Deafness" flags in the FBDE-SHCN population, this training will include targeted information on using health-plan covered interpreter services such as Linguava and outreach methods other than phone calls to better serve Deaf and Hard of Hearing (DHH) members.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: By 6/30/2026, 20.0% of hypertensive and 10.0% of diabetic FBDE members enrolled in Strive will have blood pressure and A1c check-ins incorporated in their Strive care plans respectively. The health plans will encourage Strive Case Managers to continue addressing these topics with enrolled members. EOCCO-Summit will track the number of care plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive members via bi-annual reviews of Strive care plans.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Percent of FBDE members that have blood pressure check-ins incorporated into their Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of enrolled members have blood pressure check-ins	10.0%	06/2025	20.0%	06/2026
Monitoring measure 1.2	Percent of FBDE members that have A1c check-ins incorporated into Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of enrolled members have A1c check-ins	5.0%	06/2025	10.0%	06/2026

Activity 2 description: By 6/30/2026, at least 25.0% of FBDE members enrolled in Strive Health will have controlled blood pressure, at least 20.0% will have controlled HbA1c rates, and 8.0% or fewer will progress in their disease. This will be assessed by tracking these readings through bi-annual Strive care plan monitoring and internal EOCCO-Summit claims data on CKD and ESRD diagnoses.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percentage of FBDE members with controlled blood pressure readings as measured through Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of members on care plans reported blood pressure readings of 140/90 mmHg or below	25.0%	06/2025	50.0%	06/2026
Monitoring measure 2.2	Percentage of FBDE members with controlled HbA1c rate as measured through Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

0% of members on care plans reported HbA1c levels of 9.0% or below	10.0%	06/2025	20.0%	06/2026

Monitoring measure 2.3	Percentage of FBDE members who have progressed in their disease, as measured through internal EOCCO-Summit claims data. Note: The target & benchmark are both higher than the current state of 0% since the project team expects this value to initially increase when FBDE member enrollment in Strive increases.			
Baseline or current state (05/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of members enrolled in Strive Health have progressed in their disease	10.0%	12/2024	8.0%	12/2025

Activity 3 description: The EOCCO-Summit team will submit a request to the Analytics team to include a functional limitations or disabilities flag to the Strive Health eligibility file. By 12/31/2024, the Analytics team will have completed the request and Strive Health will begin incorporating this knowledge into member outreach efforts and building care plans.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Presence of functional limitations and/or disability flags on Strive Health eligibility file			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Functional limitations and/or disabilities flags are not incorporated into Strive Health eligibility file	Functional limitations and/or disabilities flags are incorporated into Strive Health eligibility file	12/2024	[Same as target]	[Same as target]

Activity 4 description: The EOCCO-Summit Quality team will collaborate with Strive Case Managers to provide them resources to better address social determinants of health impacting members' health outcomes, especially those with functional limitations and/or disabilities. By 12/31/2024, the CCO project team will provide Unite Us refresher trainings to all Strive Case Managers and will share the health plan Community Resource Guide, which includes a catalog of region-specific services for food, housing, and transportation needs.

☒ Short term or ☐ Long term

Monitoring measure 4.1	Percent of member-facing Strive Health Case Managers given Unite Us CIE refresher trainings			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Case Managers have been given a refresher training	50%	09/2024	100%	12/2024

Monitoring measure 4.2	Percent of Strive Health Case Managers who have access to Eastern Oregon Community Resource Guide			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of Strive Health Case Managers have access to Guide	100% of Strive Health Case Managers have access to Guide	08/2024	[Same as target]	[Same as target]

Project 507: Improving Health Outcomes of Non-dual Medicaid Members with Chronic Kidney Disease

A. Project title: Improving Health Outcomes of Non-dual Medicaid Members with Chronic Kidney Disease

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

If continued, insert unique project ID from OHA: 507

B. Components addressed

1. Component 1: SHCN: Non-duals Medicaid
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** EOCCO made progress on this project and associated activities in the past year. After receiving buy-in from the CCO's Clinical Advisory Panel and Medical Director, the EOCCO Quality team contacted engaged primary care clinics to introduce them to a Strive Health representative, who offered providers learning sessions and engaged them in the case management process. Providers were given educational materials and sample workflows on how their patients may engage with Strive Health.

   Enrollment in Strive Health's Kidney Hero program has since grown to 86 non-dual Medicaid members, which comprises 25.0% of the eligible member population. Throughout 2023 EOCCO members ages 18 and up with chronic kidney disease (CKD) or end-stage renal disease (ESRD) were connected to Strive Health via provider referral, EOCCO Case Manager referral, member mailings resulting in a self-referral, and/or direct phone outreach from Strive. Strive Case Managers created and maintained treatment or care plans for 55 members (64.0% of enrolled members), which are shared with each member's care team as well as the CCO and contain the data points listed within Activities 1 and 2. The CCO also onboarded five Strive Health Case Managers to the Unite Us Community Information Exchange (CIE) platform to facilitate referrals to resources outside of the medical scope.

   EOCCO conducted REALD-GI analysis using data from both OHA 834 enrollment files and the OHA REALD-SOGI Data Repository. The project team found that EOCCO members enrolled in Strive's Kidney Hero program still have significantly more functional limitations and/or disability flags across nearly all categories than EOCCO's overall membership on SHCN plans. Project 507: Table 1 demonstrates this difference:

   Project 507: Table 1. *Functional Limitation and Disability Flags Across EOCCO, SHCN, and Strive-Enrolled EOCCO Member Populations*

Functional Limitation & Disability Flags	% of All EOCCO SHCN Members w/ Flag *(n=32,967)*	% of Strive Members w/ Flag *(n=86)*	% of Strive Members w/ Care Plan w/ Flag *(n=55)*	% of Strive Members w/o Care Plan w/ Flag *(n=31)*
Blindness	6.2%	**12.8%**	9.1%	**19.4%**
Deafness	5.3%	2.3%	1.8%	**3.2%**
Walking	12.0%	**26.7%**	25.5%	29.0%
Dressing	6.0%	9.3%	7.3%	12.9%
Errands	11.3%	15.1%	**18.2%**	9.7%
Memory	15.7%	12.8%	12.7%	12.9%

Limited Activity	11.1%	14.0%	**16.4%**	9.7%

Most notably, the prevalence of difficulty walking and blindness is more than double among Strive-enrolled members than in the full SHCN plan population. The project team also reviewed the prevalence of these limitations and disabilities among those enrolled in Strive who had a care plan on file versus those who did not have a care plan. This analysis revealed that many more members *without* a care plan have a flag for blindness (19.4%) than those on a care plan (9.1%), the prevalence of difficulty walking is roughly the same between those with and without care plans, and members on care plans (16.4%) had higher reported prevalence of limited activity compared to members without care plans (9.7%). It is difficult to draw conclusions from these findings as there is likely some selection bias at play related to which members choose to enroll in Strive and create care plans with their Case Managers. Regardless, there is clearly a higher prevalence of functional limitations and/or disabilities among members enrolled in Strive than those who are not, indicating that a greater focus should be placed on providing support via Strive programming to individuals with those disabilities and limitations.
Note that the project team conducted similar analysis to the table above for 2024 monitoring measures 1.1, 1.2, 2.1, 2.2, and 2.3. Due to the small sample size of the Strive-enrolled population with care plans no significant findings on the relationship between blood pressure control, A1c control, or disease progression and functional limitations/disability status were discovered. The full data summary can be found in Project 507: Table 2, Table 3, and Table 4.

The project team conducted further REALD-GI analysis and stratified available race, ethnicity, and language data for enrolled Strive members. The team ultimately found that the project populations roughly aligned with the overall EOCCO member population in race, ethnicity, and language categories. There was no gender identity data provided for Strive enrolled members in OHA's REALD-SOGI Data Repository file, so GI analysis was not performed for this project.

EOCCO recognizes the significance that REALD-SOGI data yields when evaluating this project population for health disparities. Though collecting this data poses challenges, EOCCO will continue to look for new ways to increase data completeness through an increased focus on gathering social needs and enhanced demographic data through the Accountable Health Communities (AHC) screening initiative. Please see Project 91 "Improvement and Stratification of Health Equity Data" for more details on REALD-SOGI data integration plans. In the meantime, EOCCO has incorporated data from OHA's REALD-SOGI Data Repository file into an existing member demographic data file for use in the 2024 TQS and other member-level projects.

Once sexual orientation (SO) data is made available through the OHA Repository, EOCCO will incorporate these fields into its existing demographic file and internal Data Warehouse. Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to identify disparities. Once disparities are identified, the CCO will examine potential root causes for these inequities and revise or create interventions to address these causes.

2. **Describe whether last year's targets and benchmarks were met (if not, why):**

   - Monitoring Measure 1.1: The project team partially met the target of incorporating blood pressure or hypertension check-ins to Strive care plans for at least 25% of diabetic or hypertensive members by December 2023. While 38.4% of hypertensive members had this check-in incorporated, only 9.3% of diabetic members had this data recorded. The team chose to split this measure into two values (presence of blood pressure check-in and presence of A1c check-in) moving forward and adjusted the targets and benchmarks accordingly.
   - Monitoring Measure 2.1: This project met the target of at least 5% of members with blood pressure check-ins reported controlled pressure readings (<140/90) by 12/2023. As of this report, 50.9% of members who were monitored for blood pressure had a controlled pressure reading.

- Monitoring Measure 2.2: This project met the target of at least 5% of members with A1c check-ins reporting a controlled A1c (<9.0%) by 12/2023. As of this report, 10.9% of members with A1c check-ins reported a controlled value.
- Monitoring Measure 2.3: The Strive Case Management team was not able to provide glomerular filtration rate (GFR) data for this measure so this target was not achieved. This measure will be removed from this project moving forward.
- Monitoring Measure 2.4: This project met the target of at least 75% of members enrolled in Strive Health *not* progressing in their disease state by 12/2023. As of this report, 90.5% of members had *not* progressed in their disease state. This measure will be reported inversely moving forward as the percentage of members who progressed in their disease.
- Monitoring Measure 3.1: The CCO did not achieve the target (requesting the addition of functional limitations and/or disability flags to the Strive Health eligibility file) or benchmark (ensuring that the Analytics team incorporated these flags into the file) since the last TQS submission. This was due to staffing turnover on both the TQS project and Analytics team. Both teams are now fully staffed and attention will be redirected to completing this task in the coming year.

3. **Lessons learned over the last year:**
   Because the Strive Health initiative was relatively new at the time of the previous TQS submission, the project team has learned a great deal about working and coordinating care with this case management vendor during this time. Although EOCCO member enrollment in the Kidney Hero program was successful, both Strive staff and the CCO found it challenging to notify providers which of their members are eligible for Strive's kidney programs. The project team ultimately found it more effective for the CCO to send initial communications to providers on this program rather than having Strive staff "cold-call" clinics.

   Another challenge with this project over the past year has been limited engagement with the Unite Us platform by the five Strive Health Case Managers that were granted access to the tool. This has made it difficult for the Strive team to effectively address social factors impacting members' health, which will be addressed through new intervention Activity 4, described below.

D. Brief narrative description

1. **Project population:**
   The population for this project is EOCCO members ages 18 and up with CKD or ESRD diagnoses who are eligible for and have enrolled in the Strive Health Kidney Hero program. The focus subgroup will be individuals in this group with functional limitations and/or disabilities, as defined in the OHA 834 enrollment files.

2. **Intervention (address each component attached):**
   The project team will continue the two intervention activities outlined in the 2023 submission and has added one new intervention to better address upstream determinants of health outcomes for members with CKD. All activity progress and monitoring measures will be shared with the EOCCO Clinical Advisory Panel (CAP) for continued oversight on the workflows and progress to ensure that members with SHCN are receiving quality care.
   - Continued Intervention: Strive Health will create and maintain care plans alongside the members every 8-9 weeks and will share these plans with member's PCP, insurer, and any other provider/specialist that is required for quality care. Care plans will include clinical data points such as A1c levels and blood pressure screenings as well as non-clinical documentation on services such as social determinants of health screenings and mental health support. The EOCCO Analytics department will continue reporting on disease state progression for Strive-enrolled members in order to track health outcomes for program participants.

- Continued Intervention: The project team will continue working with the CCO Analytics team to integrate functional limitations and/or disability flags to the Strive Health eligibility file to assist the Strive team in conducting appropriate outreach and referrals for all members.
- New Intervention: The project team will collaborate with Strive Case Managers to provide them resources to better address social determinants of health impacting members' health outcomes. This will be done by providing additional training on the Unite Us CIE tool and sharing the CCO's Community Resource Guide.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: By 6/30/2026, 60.0% of hypertensive members and 25.0% of diabetic members enrolled in Strive will have blood pressure and A1c check-ins incorporated in their Strive care plans respectively. The CCO will encourage Strive Case Managers to continue addressing these topics with enrolled members. EOCCO will track the number of care plans that have blood pressure and A1 check-ins incorporated for diabetic and hypertensive members via bi-annual reviews of Strive care plans.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Percent of members that have blood pressure check-ins incorporated into their Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
38.4% of enrolled members have blood pressure check-ins	50.0%	06/2025	60.0%	06/2026
Monitoring measure 1.2	Percent of members that have A1c check-ins incorporated into Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9.3% of enrolled members have A1c check-ins	20.0%	06/2025	25.0%	06/2026

Activity 2 description: By 6/30/2026, at least 70.0% of members enrolled in Strive Health will have controlled blood pressure, at least 20.0% will have controlled HbA1c rates, and 6.5% or fewer members will progress in their disease. This will be assessed by tracking these readings through bi-annual Strive care plan monitoring and internal EOCCO claims data on CKD and ESRD diagnoses.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percentage of members with controlled blood pressure readings as measured through Strive care plans			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
50.9% of members on care plans reported blood pressure readings of 140/90 mmHg or below	60.0%	06/2025	70.0%	06/2026
Monitoring measure 2.2	Percentage of members with controlled HbA1c rate as measured through Strive care plans			

Baseline or current state (06/2024)	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
10.9% of members on care plans reported HbA1c levels of 9.0% or below	15.0%	06/2025	20.0%	06/2026
Monitoring measure 2.3	Percentage of members who have progressed in their disease, as measured through internal EOCCO claims data			
Baseline or current state (05/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
10.5% of members enrolled in Strive Health have progressed in their disease	8.5% or below	06/2025	6.5% or below	07/2025

Activity 3 description: The EOCCO Quality team will submit a request to the EOCCO Analytics team to include a functional limitations or disabilities flag to the Strive Health eligibility file. By 12/31/2024, the Analytics team will have completed the request and Strive Health will begin incorporating this knowledge into member outreach efforts and building care plans.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Presence of functional limitations and/or disability flags on Strive Health eligibility file			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Functional limitations and/or disabilities flags are not incorporated into Strive Health eligibility file	Functional limitations and/or disabilities flags are incorporated into Strive Health eligibility file	12/2024	[Same as target]	[Same as target]

Activity 4 description: The EOCCO Quality team will collaborate with Strive Case Managers to provide them resources to better address social determinants of health impacting members' health outcomes, especially those with functional limitations and/or disabilities. By 12/31/2024, the CCO project team will provide Unite Us refresher trainings to all Strive Case Managers and will share the CCO's Community Resource Guide, which includes a catalog of region-specific services for food, housing, and transportation needs.

☒ Short term or ☐ Long term

Monitoring measure 4.1	Percent of member-facing Strive Health Case Managers given Unite Us CIE refresher trainings			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Case Managers have been given a refresher training	50%	09/2024	100%	12/2024

Monitoring measure 4.2	Percent of Strive Health Case Managers who have access to EOCCO Community Resource Guide			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of Strive Health Case Managers have access to Guide	100% of Strive Health Case Managers have access to Guide	08/2024	[Same as target]	[Same as target]

New Project: Reducing Acute Care Readmission for Members with SPMI

A. Project title: Reducing Acute Care Readmission for Members with SPMI

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

If continued, insert unique project ID from OHA: n/a

B. Components addressed

1. Component 1: Serious and persistent mental illness
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose an item

C. Project context: Complete the relevant section depending on whether the project is new or continued.

New projects

Why was this project chosen? What gap does it address? Include CCO- or region-specific data and race, ethnicity, language, disability and gender identity (REALD & GI) data for the project population.

Acute Care Follow-up care for members with severe and persistent mental illness (SPMI) is crucial to maintaining stability post-discharge from Acute Care. Follow-up requires ongoing engagement in treatment to minimize readmissions to acute care settings. Effective Acute Care monitoring, transition planning, and stabilization follow-up demand coordinating efforts among various stakeholders including the CCO, Community Mental Health Programs (CMHPs), and Acute Care Facilities. Recognizing the critical role follow-up plays in the care plan of members discharged from acute care, EOCCO aims to reduce readmissions by leveraging and strengthening its network of Peer Support Specialists and Peer Wellness Specialists (Peers).

While EOCCO has a strong structure in place to maintain up-to-date progress-related information and support discharge planning within Acute Care settings, it can be difficult to receive information from Acute Care Hospitals. Currently, 13.4% of EOCCO members experience readmission within 90 days of an acute care discharge, 15.6% readmit within 180 days and 19% readmit within 365 days. Moreover, timely clinical follow-up services are hindered by member discharge locations and workforce capacity constraints. Therefore, considering these challenges, EOCCO is focusing this project on interventions that can be directly implemented within the CCO and CMHPs, minimizing reliance on outside stakeholders. While EOCCO continues to increase the frequency and quality of communication with members in Acute Care settings, there are currently no clear baselines or measurable benchmarks that can be tracked to demonstrate improvement in this area. Therefore, EOCCO will use services rendered by Peers metric to assess timely follow-up and monitor member readmission outcomes. EOCCO acknowledges its limitations in directly influencing Acute Care Hospital structures, processes, or performance, but aims to directly improve individual follow-up through Peer services.

EOCCO understands and emphasizes the importance of developing a Peer workforce and utilizing Peer services to fill gaps in Acute Care follow-up for SPMI members. Peers are community members who use their lived experience and professional training to provide an array of services for people recovering from addiction or experiencing a mental health issue. Peers can engage members with SPMI in a peer-led approach, often without the constraints of clinicians or clinical settings, enhancing member comfort and trust. The National Institutes of Health (NIH) states that “Peer support specifically targeted at discharge and the transition to outpatient mental health care might mitigate potential harm resulting from disruption to clinical and social support and, thus, prevent readmissions.” OHA provides guidance in the Fee Schedule as to what codes Peers can render services for, including; G0177, H0023, H0038, H0039, H0039, H0046, H2011, H2011, H2014, H2023, T1013, and T1016.

Recognizing the value of Peers, EOCCO prioritizes expanding the Peer workforce across its service area and advocates for their utilization wherever feasible to address workforce shortages and gaps in follow-up services. This

approach aims to enhance member engagement and increase member participation in ongoing services where Peer interventions are most beneficial. The National Institutes of Health (NIH) states that "Peer support specifically targeted at discharge and the transition to outpatient mental health care might mitigate potential harm resulting from disruption to clinical and social support and, thus, prevent readmissions." They note that benefits of Peer support include reduced acute care and hospital admissions and readmissions, an increase in self-esteem and confidence, increased social support and social functioning, increased engagement in self-care, and increase in overall wellness.[2]

To understand the unique needs of member with SPMI and how the Peer workforce can support them, EOCCO conducted a REALD-GI analysis using OHA 834 enrollment files and OHA REALD-SOGI Data Repository data. The analysis revealed significant disparities in disability and functional limitations among the 202 EOCCO members with SPMI who received treatment in Acute Care settings. Specifically, the population showed significantly higher prevalence of Disability/Functional Limitation categories of Errands, Limited Activity, and Memory, as shown in the chart below. This underscores the need for members in Acute Care settings to have access to Peer services, which provide support and assistance in navigating the healthcare system effectively.

New Project: Table 1*. Disability and Functional Limitation Rates in EOCCO members with SPMI Receiving treatment in Acute Care*

DISABILITY/FUNCTIONAL LIMITATION	Project Population (%)	Overall EOCCO Member Population (%)	Difference from Overall EOCCO Member Average (%)
Blindness	4.74	2.76	+1.98
Deafness	4.74	2.34	+2.4
Walking	9.00	5.33	+3.67
Dressing	5.69	2.69	+3
Errands	19.43	5.08	+14.26
Memory	19.91	7.08	+12.83
Limited Activity	30.33	4.97	+25.36

The analysis also revealed that the project population's race, ethnicity, and language roughly aligned with the overall EOCCO member population in REALD-GI category distribution. Due to a lack of data from the REALD-SOGI Data Repository file, no GI analysis was performed for this project. See New Project: Table 2 for the full demographic analysis.

EOCCO recognizes the significance that REALD-SOGI data yields when evaluating this project population for health disparities. Though collecting this data poses challenges, EOCCO will continue to look for new ways to increase data completeness through an increased focus on gathering social needs and enhanced demographic data through the Accountable Health Communities (AHC) screening initiative. Please see Project 91: Improvement and Stratification of Health Equity Data for more details on REALD-SOGI data integration plans.

Once sexual orientation (SO) data is made available through the OHA Repository, EOCCO will incorporate these fields into its existing demographic file and internal Data Warehouse. Project leads will then stratify TQS project monitoring measures and health outcome data by SO categories along with REALD-GI categories in order to identify disparities. Once disparities are identified, the CCO will examine potential root causes for these inequities and revise or create interventions to address these causes.

[2] Gillard S, Bremner S, Patel A, et al. Peer support for discharge from inpatient mental health care versus care as usual in England (ENRICH): a parallel, two-group, individually randomized controlled trial. Lancet Psychiatry. 2022;9(2):125-136. doi:10.1016/S2215-0366(21)00398-9).

D. Brief narrative description

1. **Project population:** Members with SPMI who have Acute Care Hospitalizations

2. **Intervention (address each component attached):**
The goal of this project is to ultimately reduce Acute Care readmissions for members with SPMI. Acute Care readmissions are monitored on a regular basis by the EOCCO data team, and that data is reviewed by EOCCO Quality Improvement staff to inform performance improvement efforts and understand progress towards specific goals identified (see measures in Activity 2, for example). The structure and process of care coordination for members in Acute Care is well established, however, there is a growing emphasis on the role Peer support can play in supporting members upon discharge from Acute Care.

   In an effort to increase Peer utilization, EOCCO designed two core interventions, intended to meet the goal of reducing acute care readmissions. First, EOCCO will bolster Peer Services through recruitment efforts that will increase the number of Peers available to provide services for EOCCO members, specifically members who are discharged from Acute Care settings. Second, EOCCO will provide training and technical support for CMHPs related to Peer utilization, and Peer supervision.

   With this new project, EOCCO aims to reduce Acute Care readmissions by strengthening the Peer workforce in EOCCO's service area and enhancing the integration of Peers working in CMHPs for immediate follow-up care after members are discharged from Acute Care. EOCCO continues to engage in a targeted recruitment campaign in Eastern Oregon called "Come Care with Us," which seeks to recruit and connect potential behavioral healthcare workforce professionals, including Peers, with open positions in all 12 coverage counties. This campaign includes recruitment materials such as produced videos featuring staff from five counties sharing their experiences, radio advertisements, in-person recruitment events, and targeted social media content. As of Q1 2024, EOCCO has 115 Peer Support Specialists working for CMHPs.

   Additionally, EOCCO is facilitating the launch of a Peer Conference in August 2024. This conference offers Peers and prospective Peers a platform to convene, participate in training and educational sessions, share their experiences, build cohesion among existing Peers, and attract new Peer recruits to the workforce. This intervention aims to increase overall Peer workforce, as well as an opportunity for peers to increase their skills and understand the critical role they play in meeting the needs of members specifically with SPMI. EOCCO understands the importance of Peer services and understands this as an important step to building a highly skilled, supported, and robust workforce needed to meet the needs of members in its 12-county service area.

   EOCCO will provide direct technical support, following broader training opportunities provided to all 12 CMHPs in 2024. These training sessions will provide tips and tricks for identifying gaps in services and utilizing Peers where appropriate and emphasizing the role of Peers within clinical workflows. The intent is to engage Peer supervisors and Peers themselves. Training and technical support will be provided by EOCCO's Behavioral Health Director and Traditional Health Worker Liaison.

   EOCCO will continue to monitor disparities in available REALD-SOGI data to understand inequities in members receiving Peer support services following acute care stays, as well as for members being readmitted to acute care settings. EOCCO believes that increases in Peer support services will help to support the identified Disability/Daily Functioning flags and address Social Determinants of Health needs and support the mitigation of those needs by connecting them to Community Based Organizations (CBOs) and Supported Employment services.

E. Activities and monitoring for performance improvement (duplicate until all activities and measures are included)

Activity 1 description: EOCCO will focus on recruitment of Peers and provide technical assistance training on how to best utilize Peer services and integrate to increase workforce capacity and peer utilization. By 01/2026, the CCO will

have held two Peer conferences, increased the number of Peers employed by Eastern Oregon CMHPs to 130, and will hold regular technical assistance meetings to discuss Peer utilization and support with CMHPs.

☒ Short term or ☐ Long term

Monitoring measure 1.1	EOCCO will hold an annual Peer Conference in Eastern Oregon.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No conferences held by EOCCO to recruit and retain Peers	1 conference held by EOCCO to recruit and retain Peers	10/2024	2 conferences held by EOCCO to recruit and retain Peers	01/2026
Monitoring measure 1.2	EOCCO will monitor the increase in employment of CMHP Peers through quarterly THW reports.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
115 CMHP peers throughout the 12-county coverage area	120 peers throughout the 12-county coverage area	01/2025	130 peers throughout the 12-county coverage area and review strategies for maintaining CMHP Peers	01/2026
Monitoring measure 1.3	EOCCO will create a comprehensive training on Peer utilization and establish regular CMHP virtual technical support.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No network-wide Peer utilization focused training	1 network-wide Peer utilization focused training	01/2025	Regular TA meetings to discuss Peer utilization and support with CMHPS	01/2026

Activity 2 description: EOCCO's data team will monitor Peer encounters within 7 days and within 6 months from a member's Acute Care discharge and by 01/2026 will increase the percentage of members who have at least one Peer code encountered within 7 days of discharge to 20% and will average 13 Peer services billed for each of those members within 6 months of discharge. By 01/2026, EOCCO will have reduced the percentage of project population members readmitting within 90 days of discharge to 9.4%, readmits within 180 days of discharge to 11.6%, and readmits within 365 days to 15.0%. EOCCO's Quality Improvement team will compare Peer utilization and readmission rates to identify trends, assess the impact of Peers on reducing readmissions, and find opportunities for further Peer training.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Percentage of members with at least one Peer code encountered and billed for within 7 days of discharge, as determined by claims data.			
Baseline or current state (06/2024)	**Target/future state**	**Baseline or current state**	**Target/future state**	**Baseline or current state**
14.5% of members have at least one Peer code encountered within 7 days of discharge from Acute Care	16.5%	01/2025	20.0%	01/2026

Monitoring measure 2.2	Average number of Peer codes billed for members within 6 months of Acute Care discharge, as determined by claims data.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average of 9.1 Peer services billed within 6 months for members who had a Peer service within 7 days of discharge from Acute Care	Average of 11 Peer services billed	01/2025	Average of 13 Peer services billed	01/2026
Monitoring measure 2.3	Percentage of members with readmission to Acute Care (2 stays) within 90 days of discharge, as determined by claims data.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
13.4% members readmitted within 90 days of discharge from Acute Care	11.4%	01/2025	9.4%	01/2026
Monitoring measure 2.4	Percentage of members with readmission to Acute Care (2 stays) within 180 days of discharge, as determined by claims data.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
15.6% members readmitted within 180 days of discharge from Acute Care	13.6%	01/2025	11.6%	01/2026
Monitoring measure 2.5	Percentage of members with readmission to Acute Care (2 stays) within 365 days of discharge, as determined by claims data.			
Baseline or current state (06/2024)	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
19% members readmitted within 365 days of discharge from Acute Care	17%	01/2025	15%	01/2026

Section 2: Supporting information (optional)

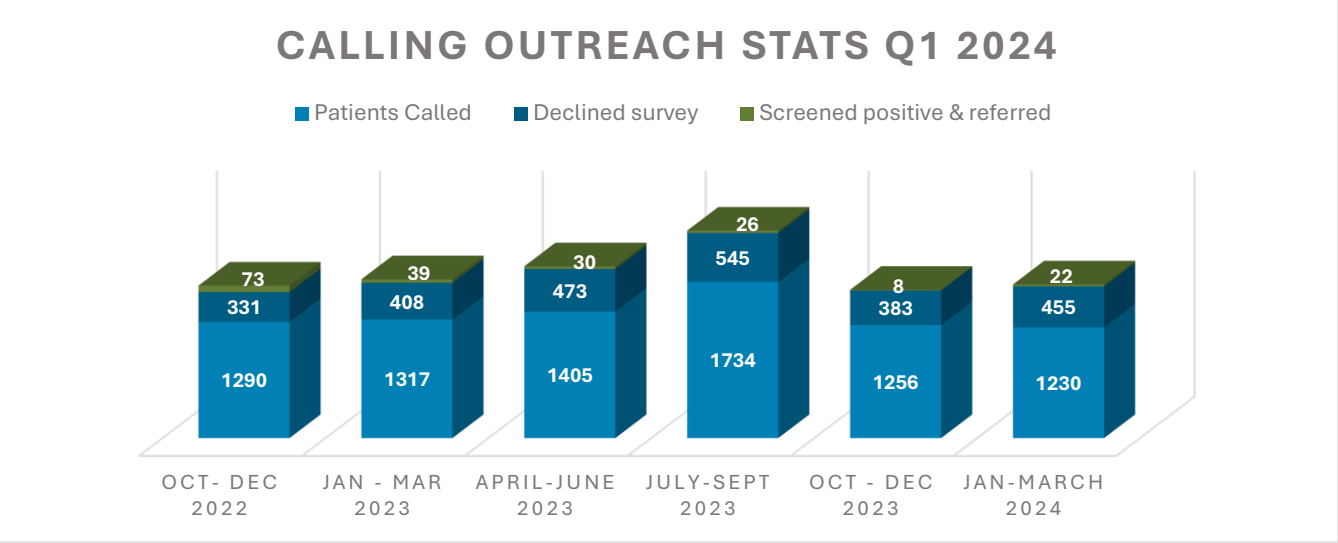
Attach other documents relevant to the TQS components or your TQS projects, such as driver diagrams, root-cause analysis diagrams, data to support problem statement, or member materials. Please add any attachments to the table of contents.

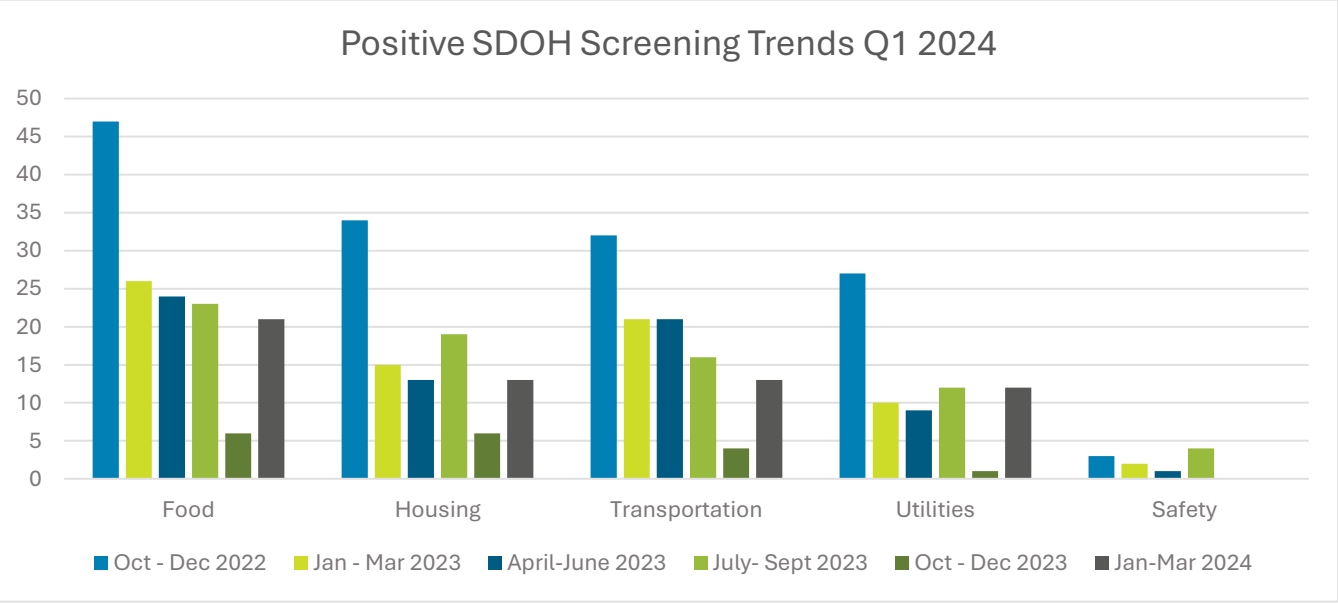
Project 91: Attachment 1. SDOH Social Screening & Referral Results

EOCCO Social Determinants of Health Social Screening & Referral Results

Data Trends by Quarter (Q4 2022 – Q1 2024)

All outreach calls were conducted by a trained member of the ORPRN Outreach team in the members' preferred language.





Project 91: Attachment 2. Gender Identity Configuration Service Request

UMP Gender Identity

Service Request 1000943

Requirement: Receive and store gender identity by 1/1/2022 specifically for WSRX, however creating a process to work for any Trading Partner.

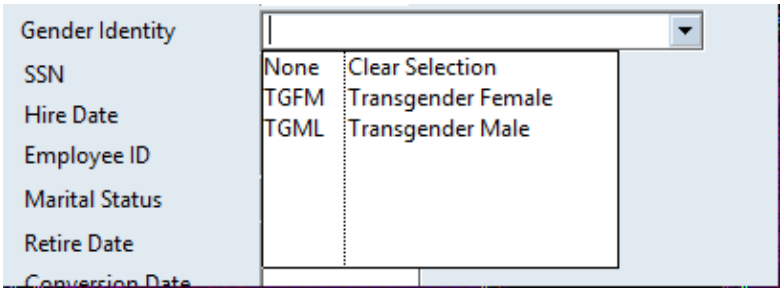
Decisions:

Map new Gender Identity data in the Facets Gender Identity field.

Continue to receive Legal Gender in DMG03 with values of F/M/U. These are mapped to Gender field in Facets and will remain unchanged.

Moda proposed that Regence send values of M/F/X in REF*23 position 3 for Gender Identity mapping and these would be mapped to Facets, Gender Identity field. Examples would be: REF*23*00M (MALE) / REF*23*00F (FEMA) / REF*23*00X (XGEN).

After further review and discussions EDI is going to reach out internally to the Sales team about re-engaging Regence on changing the segment previously proposed for passing Gender Identity. This will allow Moda to have a more streamlined processes that fits for any 834 TP.



Proposed:

(In progress) For WSRX, receive M/F/X identifier on 834 using Loop 2750 and map Facets MEME_MCTR_GENP_NVL using the following values: FEMA if F, MALE if M and XGEN if X. This matches what Regence is doing for WSRX when receiving data from HCA and would be a direct map. However, EDI is gathering additional information on how XGEN is being defined.

For all other TP's we recommend we receive Gender Identity details using Loop 2750 as well and map to Facets MEME_MCTR_GENP_NVL. Moda we would receive the value on the 834 and store the 4-character value in Facets.

Loop 2750 -Reporting Category

LX*1
N1*75*Gender Identity
REF*ZZ*XGEN

In addition to values stored for WSRX, the following Gender Choice Suggestions will be used within Moda:

- Male (MALE)
- Female (FEMA)
- Transgender (TRAN)
- Cisgender* (CIGN)
- Gender Non-Conforming (GNNC)
- Non-Binary/Third Gender (NBGN)
- Questioning (QUES)
- Prefer not to answer (PRNA)
- Another_____(ANTH)
- Undefined/Unspecified

*Definition of Cisgender: of, relating to, or being a person, whose gender identity corresponds with the sex the person had or was identified as having at birth.

For Proprietary files, these implementations will be handled individually upon request from a TP. Gender Identity for PROP files will be housed in the same Facets Gender Identity field as we are using for 834 files.

Outstanding item –

IT/kelley will reach out to Karis Stoudamire-Phillips in regard to UMP specific values and inquire about the XGEN value being stored in Facets as XGEN, or if we can, or should use a value identified above.

Change history –

Date	User	Description of change
6/22/2021	C. Rambow	Add value for Another of ANTH
6/22/2021	C. Rambow	Updated description from Prefer not to say/Decline to Prefer not to answer – per Kelley C

Project 92: Table 1. REALD Analysis of CHWs serving EOCCO

Self-Identified Race, Ethnicity, Language, and Disability of CHWs serving EOCCO (n=111)		
REALD or GI Category	**Count**	**Percent**
RACE		
American Indian or Alaska Native	5	4.50
Asian or Pacific Islander	0	0.00
Black	0	0.00
Caucasian	36	32.43
Hispanic	14	12.61
Native Hawaiian	1	0.90
Not Assigned	2	0.90
Not Provided	49	44.14
Multiple	4	3.60
ETHNICITY		
Hispanic	19	17.12
Not Assigned	55	49.55
Not Hispanic	37	33.33
LANGUAGE (Primary)		
English	53	47.74
Spanish*	12	8.23
Chuukese	1	0.90
Marshallese	1	0.90
Unknown	43	38.74
Not Provided	1	0.90
**19 CHWs indicated they speak Spanish and English (17 are HCIs)*		
DISABILITY		
Living with a Disability	0	0.00
Not Living with a Disability	57	51.35
Unknown	50	45.05
Not Provided	4	3.60

Project 92: Table 2. REALD and GI Analysis of EOCCO Members who utilized CHW services

REALD and GI Analysis of EOCCO Members who utilized CHW services in 2023 (n=1840)		
REALD or GI Category	**Count**	**Percent**
RACE		
American Indian or Alaska Native	64	3.48
Asian or Pacific Islander	7	0.38
Black	20	1.09
Caucasian	1096	59.57
Hispanic	267	14.51
Native Hawaiian	2	0.11
Not Applicable	0	0.00
Not Assigned	2	0.11
Not Provided	376	0.20
Other	3	0.16
Pacific Islander	3	0.16
ETHNICITY		
Hispanic	284	15.43
Not Assigned	238	12.93
Not Hispanic	1318	71.63
LANGUAGE [Top 5 most prevalent]		
English	1710	92.93
Spanish	106	5.76
Chuukese	1	0.05
Other	22	1.20
Not Provided	1	0.05
DISABILITY		
Blindness	78	4.24
Deafness	77	4.18
Walking	165	8.97
Dressing	81	4.40
Errands	187	10.16
Limited Activity	185	10.05
Memory	292	15.87
GENDER IDENTITY (n=28)		
Woman, Girl	8	28.57
Man, Boy	20	71.43
Non-Binary	0	0.00
Agender/No Gender	0	0.00
Gender Questioning	0	0.00
Gender Fluid	0	0.00
GenderQueer	0	0.00

Culturally Specific	0	0.00
Other, not listed	0	0.00
GENDER		
Female	918	49.90
Male	922	50.11

Project 92: Table 3. REALD and GI Analysis of EOCCO Members

REALD and GI Analysis of EOCCO Members (n=74,927)		
REALD or GI Category	**Count**	**Percent (%)**
RACE		
American Indian or Alaska Native	1958	2.61
Asian or Pacific Islander	371	0.50
Black	532	0.71
Caucasian	36162	48.26
Hispanic	17680	23.60
Native Hawaiian	31	0.04
Pacific Islander	501	0.67
Not Applicable	11	0.01
Not Assigned	41	0.05
Not Provided	17312	23.11
ETHNICITY		
Hispanic	18644	24.88
Not Hispanic	13477	17.99
Not Assigned	42806	57.13
LANGUAGE [Top 5 most prevalent]		
English	62136	82.93
Spanish	11851	15.82
Mam	157	0.21
Marshallese	55	0.07
Yue Chinese	19	0.03
DISABILITY		
Blindness	2071	2.76
Deafness	1793	2.34
Walking	3996	5.33
Dressing	2016	2.69
Errands	3806	5.08
Memory	5304	7.08
Limited Activity	3726	4.97
GENDER IDENTITY (n=755)		
Woman, Girl	273	36.16
Man, Boy	477	63.18
Non-Binary	1	0.13
Agender/No Gender	0	0.00
Gender Questioning	0	0.00
Gender Fluid	1	0.13
Gender Queer	1	0.13
Culturally Specific	0	0.00
Other, not listed	2	0.26

Project 423: Table 1. Self-Identified Race, Ethnicity, and Language of EOCCO member population

Self-Identified Race, Ethnicity and Language of EOCCO member population (n=74,927)		
REALD or GI Category	**Count**	**Percent (%)**
RACE		
American Indian or Alaska Native	1958	2.61%
Asian or Pacific Islander	371	0.50%
Black	532	0.71%
Caucasian	36162	48.26%
Hispanic	17680	23.60%
Native Hawaiian	31	0.04%
Pacific Islander	501	0.67%
Not Applicable	11	0.01%
Not Assigned	41	0.05%
Not Provided	17312	23.11%
ETHNICITY		
Hispanic	18644	24.88%
Not Hispanic	13477	17.99%
Not Assigned	42806	57.13%
LANGUAGE (Top 5 most prevalent)		
English	62136	82.93%
Spanish	11851	15.82%
Mam	157	0.21%
Marshallese	55	0.07%
Yue Chinese	19	0.03%
DISABILITY		
Blindness	2071	2.76%
Deafness	1793	2.34%
Walking	3996	5.33%
Dressing	2016	2.69%
Errands	3806	5.08%
Memory	5304	7.08%
Limited Activity	3726	4.97%

Project 423: Table 2. Self-Identified Gender Identity of EOCCO member population

Self-Identified Gender Identity of EOCCO member population (n=755)		
Gender Identity	**Count**	**Percent (%)**
Woman, Girl	273	36.16
Man, Boy	477	63.18
Non-Binary	1	0.13
Agender/No Gender	0	0.00
Gender Questioning	0	0.00
Gender Fluid	1	0.13
GenderQueer	1	0.13
Culturally Specific	0	0.00
Other, not listed	2	0.26

Project 423: Table 3. REALD and GI Analysis of EOCCO Members assigned to PCPCH BHI Clinics

REALD and GI Analysis of EOCCO Members assigned to PCPCH BHI Clinics (n=37,999)		
REALD or GI Category	**Count**	**Percent**
RACE		
American Indian or Alaska Nati	821	2.16%
Asian or Pacific Islander	171	0.45%
Black	261	0.69%
Caucasian	14984	39.43%
Hispanic	12394	32.62%
Native Hawaiian	10	0.03%
Not Applicable	7	0.02%
Not Assigned	30	0.08%
Not Provided	8746	23.02%
Other	144	0.38%
Pacific Islander	431	1.13%
ETHNICITY		
Hispanic	13046	34.33%
Not Assigned	6834	17.98%
Not Hispanic	18119	47.68%
LANGUAGE (Top 5 most prevalent)		
English	28,111	73.98%
Spanish	9,284	24.43%
Mam	153	0.40%
Marshallese	51	0.13%
Yue Chinese	11	0.03%
DISABILITY		
Blindness	969	2.55%
Deafness	793	2.09%
Walking	1650	4.34%
Dressing	892	2.35%
Errands	1639	4.31%
Limited Activity	1569	4.13%
Memory	2380	6.26%
GENDER IDENTITY (n=370)		
Woman, Girl	232	62.70%
Man, Boy	134	36.22%
Non-Binary	0	0.00%
Agender/No Gender	0	0.00%
Gender Questioning	0	0.00%
Gender Fluid	1	0.27%
GenderQueer	1	0.27%
Culturally Specific	0	0.00%
Other, not listed	2	0.54%

Project 423: Table 4. REALD Analysis of THWs serving EOCCO

REALD Analysis of THWs serving EOCCO (n=231)		
REALD or GI Category	**Count**	**Percent (%)**
RACE		
American Indian or Alaska Native	7	3.03%
Asian or Pacific Islander	3	1.30%
Black	1	0.43%
Caucasian	97	41.00%
Hispanic	18	7.79%
Native Hawaiian	2	0.87%
Not Assigned	23	9.96%
Not Provided	74	32.03%
Other	6	2.60%
LANGUAGE (Top 5 most prevalent)		
English	122	52.81%
Spanish	19	8.23%
Chuukese	1	0.43%
Marshallese	1	0.43%
Unknown	88	38.10%
DISABILITY		
Living with a Disability	5	2.16%
Not Living with a Disability	114	49.35%
Unknown	112	48.48%

Project 423: Table 5. REALD Analysis of THWs onboarded to Unite Us

REALD Analysis of THWs onboarded to Unite Us (n=23)		
REALD or GI Category	**Count**	**Percent**
RACE		
American Indian or Alaska Native	0	0.00%
Asian or Pacific Islander	0	0.00%
Black	0	0.00%
Caucasian	7	30.43%
Hispanic	5	21.74%
Native Hawaiian	0	0.00%
Not Assigned	0	0.00%
Not Provided	10	43.48%
Other	1	4.35%
LANGUAGE (Top 5 most prevalent)		
English	11	47.83%
Spanish	4	17.39%
Unknown	8	34.78%
DISABILITY		
Living with a Disability	0	0.00%
Not Living with a Disability	11	47.83%
Unknown	12	52.17%

Project 505: Table 2. MY 2023 Dental Utilization Rates Across EOCCO Service Counties

EOCCO Service County	MY 2023 Dental Utilization Rate
Baker	58.60%
Gilliam	66.15%
Grant	68.84%
Harney	59.14%
Lake	66.56%
Malheur	72.82%
Morrow	70.34%
Sherman	69.62%
Umatilla	65.78%
Union	66.85%
Wallowa	69.06%
Wheeler	57.64%

Project 507: Table 2. Blood Pressure Control for Strive-Enrolled EOCCO Members with Care Plans

BP Controlled	% of Strive Members with Care Plans	% of Members with:						
		Blindness	Deafness	Walking	Dressing	Errands	Memory	Limited Activity
yes	50.9% (28)	14.3%	3.6%	35.7%	14.3%	25.0%	17.9%	21.4%
no	9.1% (5)	0.0%	0.0%	20.0%	0.0%	40.0%	40.0%	40.0%
Not recorded	40.0% (22)	4.5%	0.0%	13.6%	0.0%	4.5%	0.0%	4.5%
Total	100.0% (55)	9.1%	1.8%	25.5%	7.3%	18.2%	12.7%	16.4%

Project 507: Table 3. HbA1c Control for Strive-Enrolled EOCCO Members with Care Plans

A1c Controlled (<9.0%)	% of Strive Members with Care Plans	% of Members with:						
		Blindness	Deafness	Walking	Dressing	Errands	Memory	Limited Activity
yes	10.9% (6)	16.7%	0.0%	0.0%	0.0%	16.7%	16.7%	33.3%
no	3.6% (2)	0.0%	0.0%	50.0%	50.0%	50.0%	50.0%	50.0%
Not recorded	85.5% (47)	8.5%	2.1%	27.7%	6.4%	17.0%	10.6%	12.8%
Total	100.0% (55)	9.1%	1.8%	25.5%	7.3%	18.2%	12.7%	16.4%

Project 507: Table 4. CKD Progression from 05/2023 to 05/2024 for Strive-Enrolled EOCCO Members

CKD Disease Progression	% of Strive Members	% of Members with:						
		Blindness	Deafness	Walking	Dressing	Errands	Memory	Limited Activity
No baseline data	30.2% (26)	45.5%	50.0%	30.4%	25.0%	30.8%	36.4%	16.7%
No change	59.3% (51)	45.5%	50.0%	52.2%	75.0%	61.5%	54.5%	66.7%
Progressed at least 1 stage	10.5% (9)	9.1%	0.0%	17.4%	0.0%	7.7%	9.1%	16.7%
Total	100% (86)	12.8%	2.3%	26.7%	9.3%	15.1%	12.8%	14.0%

New Project: Table 2. Self-Identified Race, Ethnicity, and Language of EOCCO member and project populations

Self-Identified Race, Ethnicity and Language of EOCCO member population (n=74,927), and Project Population (n=202)				
	Member Count	**Member Percent (%)**	**Population Count**	**Population Percent (%)**
Race				
American Indian or Alaska Native	1958	2.61	6	2.84
Asian or Pacific Islander	371	0.50	1	.47
Black	532	0.71	2	.95
Caucasian	36162	48.26	120	59.40
Hispanic	17680	23.60	18	8.53
Native Hawaiian	31	0.04	0	0.00
Pacific Islander	501	0.67	0	0.00
Not Applicable	11	0.01	0	0.00
Not Assigned	41	0.05	0	0.00
Not Provided	17312	23.11	55	27.22
Ethnicity				
Hispanic	18644	24.88	20	9.9
Not Hispanic	13477	17.99	147	72.77
Not Assigned	42806	57.13	35	17.34
Language [Top 5 most prevalent]				
English	62136	82.93	195	96.53
Spanish	11851	15.82	4	1.98
Mam	157	0.21	0	0
Marshallese	55	0.07	0	0
Yue Chinese	19	0.03	0	0
Disability/ Functional Limitation				
Blindness	2071	2.76	10	4.95
Deafness	1793	2.34	10	4.95
Walking	3996	5.33	19	9.40
Dressing	2016	2.69	12	5.94
Errands	3806	5.08	41	20.29
Memory	5304	7.08	64	31.68
Limited Activity	3726	4.97	42	20.79

Submit your final TQS by July 15 through the CCO Contract Deliverables Portal. (The submitter must have an OHA account to access the portal.)