Transformation and Quality Strategy

July 2024

InterCommunity Health Network CCO

Table of Contents

Section 1: Transformation and quality project details........ 2

Project #1 - Behavioral Health Clinic in East Linn........ 3

Project #2 - Monitoring the competence of individuals providing language assistance to IHN-CCO members with an identified interpreter service need. 11

Project #3 - Community Led Behavioral Health Intervention Models 16

Project #4 - Oral health integration at behavioral health facilities........ 23

Project #5 - Supporting PCPCH Member Enrollment........ 29

Project #6 - Supporting PCPCH Tier Advancement 33

Project #7 - Nurture Oregon: Supporting Pregnant People with Substance Use Disorder and Mental Health Conditions 36

Project #8 - Under Pressure: Managing High Blood Pressure to Decrease Morbidity and Mortality Risk44

Project #9 - Improving Resources for IHN-CCO members with SPMI........ 51

Section 2: Supporting information........59

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Section 1: Transformation and quality project details

Project ID	Project Title	Component(s)
434	Behavioral Health Clinic in East Linn	Behavioral Health Integration
NEW	Monitoring the competence of individuals providing language assistance to IHN-CCO members with an identified interpreter service need	- CLAS Standards - Health Equity: Cultural Responsiveness
NEW	Community Led Behavioral Health Intervention Models	Health Equity: Cultural Responsiveness
NEW	Oral health integration at behavioral health facilities to support oral health utilization for people with substance use disorder	Oral Health Integration
NEW	Supporting PCPCH Member Enrollment	PCPH Member Enrollment
436	Supporting PCPCH Tier Advancement	PCPCH Tier Advancement
NEW	Supporting Pregnant People with Substance Use Disorder and Mental Health Conditions through Project Nurture	Special Health Care Needs (SHCN): Non-dual eligible
510	Under Pressure: Managing High Blood Pressure to Decrease Morbidity and Mortality Risk	Special Health Care Needs (SHCN): Dual eligible
NEW	Improving Resources for IHN-CCO members with SPMI	Serious and Persistent Mental Illness (SPMI)

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #1- Behavioral Health Clinic in East Linn

A. Project title: Behavioral Health Clinic in East Linn

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

If continued, insert unique project ID from OHA: 434

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.

Current progress for establishing a Behavioral Health Home in East Linn County

Over the past two years, IHN-CCO has collaborated closely with Samaritan Health System to integrate behavioral health and primary care services. This partnership has been instrumental in addressing the complex healthcare needs of our community. With a specific focus on East Linn County, efforts have been underway to establish a Mental Health Home Clinic – now being referred to as the Behavioral Health Home Clinic. Despite encountering various challenges along the way, significant progress has been achieved towards the realization of the Behavioral Health Home initiative in East Linn County. This comprehensive assessment reflects our commitment to transparency and continuous improvement as we strive to overcome obstacles and enhance access to quality care for all individuals in need. **Table 1.** includes the monitoring measures included in the previous submission, the outcomes, and the barriers experienced while working to meet the monitoring measures.

Table 1. 2023 Monitoring Measures, the outcome and barrier to meeting the measure, and next steps for 2024.

Monitoring Measures	Outcome	Barriers	Next steps for 2024
Establishing a provider panel.	Not met for 2023 - In process.	Unable to find a location for the clinic and funding to move forward.	Developing a Risk adjusted panel size model instead of the traditionally PCP panel size.
Assigning IHN-CCO members to the facility.	Not met for 2023- In process.	No members were able to be assigned, VBP contracts could not be created, and Epic configuration did not occur because a location for the clinic could not be established. A few locations were identified, but Samaritan was unable to obtain the space.	Follow the same model as the IHN-CCO Primary Care Clinic, in assigning patients who do not have a PCP, and co-occurring diagnosis of Diabetes, SUD and mental health condition.

Creating MOUs and Value-Based Payment (VBP) contracts with the Behavioral Health Home.	Not Met for 2023 - In process.		In the process of researching different models and what VBP contract would look like.
EPIC configuration.	Not met for 2023 - In process.		Will start the EPIC build in August 2024.
Establishing workflows between primary care and behavioral health.	Monitoring Measure Met.	Care coordination workflows have been identified, in addition to some initial workflows internally including the patient intake and 1st 1–2-hour intake BH process. All 3 appointments in the same day if possible: – 1st visit is with PCP (60 Mins) – 2nd visit with BH (60 Mins) – 3rd with Nutritionist/ Dietician / or Health coach	The Clinic is set to open in January 2025. Once open, the workflows will be evaluated and changes will be made depending on results.
Opening the Behavioral Health Home in East Linn County.	Not met for 2023 - In process.	Multiple locations were identified and SHS attempted to acquire the space, but it was unsuccessful. A space was secured in January 2024.	A space has been identified and construction will begin July 2024 and is set to open in January 2025.

Most of the outcome measures established for 2023 were not met, but they are in progress and are on track to be met by first quarter of 2025. Significant strides were made in early 2024 to support the implementation of the Behavioral Health Home. This progress prompted IHN-CCO to proceed with including the behavioral health integration at the Behavioral Health Home clinic in East Linn County, a TQS project.

To ensure the success of the project, stakeholders and partners convened to revisit the foundational goals and monitoring measures of the initiative. The overarching aim of the Behavioral Health Home clinic remains focused on reducing healthcare costs, enhancing the quality of care, fostering member engagement in their healthcare journey, and improving health outcomes for high-risk IHN-CCO members. A detailed timeline has been developed to guide the continued implementation of the Behavioral Health Home Clinic:

- April 2024 – July 2024.
    - Budgeting Prep for 2025 staffing & providers.
    - Design Alternate payment model vs Nonproductivity model
        - Reimbursement model: Capitated model.

        - Peer support with Chance.
    - Visit type standards specific to this model.
    - Research team support:
        - Common set of metrics.
        - Publish study.
        - Evaluate the success of the program.
- July 2024 – January 2025
    - Geriatrics clinic move-out: July 2024.
        - The clinic space is currently occupied by a geriatrics clinic.
    - Construction: July 2024 – October 2024.
        - The construction will ensure the creation of exam rooms, therapy/consultation rooms, and HbA1c point of care testing.
    - Move in: October 2024.
        - Assign provider and establish a patient panel.
    - Go-Live Launch: January 2025.
        - Appointments begin.

Assessment of IHN-CCO members in the Behavioral Health Home service region.

In 2023 approximately 8.2% of IHN-CCO members (with continuous enrollment) 18 years and older had a diabetes diagnosis. The average per member per month (PMPM) health care costs for these members was about $1,559 dollars. This PMPM is about 245 percent higher than the PMPM for adult IHN-CCO members without a diabetes diagnosis. In addition, anxiety disorder, substance use disorders (SUD), depressive disorders, and post-traumatic stress disorder (PTSD) are in the top five conditions of IHN-CCO members. The average PMPM for IHN-CCO members with co-occurring diabetes, SUD, and mental health condition is $3,188 dollars (equaling about 0.3% of the IHN-CCO population and 3.6% of the IHN-CCO diabetic population). Given the high health care costs among IHN-CCO diabetic members and the prevalence of mental and behavioral health conditions throughout the adult population, our goal is to evaluate the Behavioral Health Home model in addressing both physical and mental/behavioral health needs of IHN-CCO members with diabetes who also have comorbidities of SUD and/or mental illness. The Behavioral Health Home will be in Lebanon – East Linn County. About 13.5% of IHN-CCO's 2023 adult population reported living in Lebanon.

Lebanon is an appropriate area to test the Behavioral Health Home model because the IHN-CCO population living in the area have a similar race, ethnicity, language spoken at home, disability rates, and gender identity profile when compared to the IHN-CCO population in its entirety. Data in **Table 2.** indicate that the population also has similar health care spending trends and Emergency Department (ED) utilization trends as the general IHN-CCO population, with members living in Lebanon having slightly higher PMPM overall health care costs. The table highlights the sizeable difference in PMPM costs for members with diabetes and comorbidities of SUD and/or Mental illness for both IHN-CCO as whole and members residing in Lebanon.

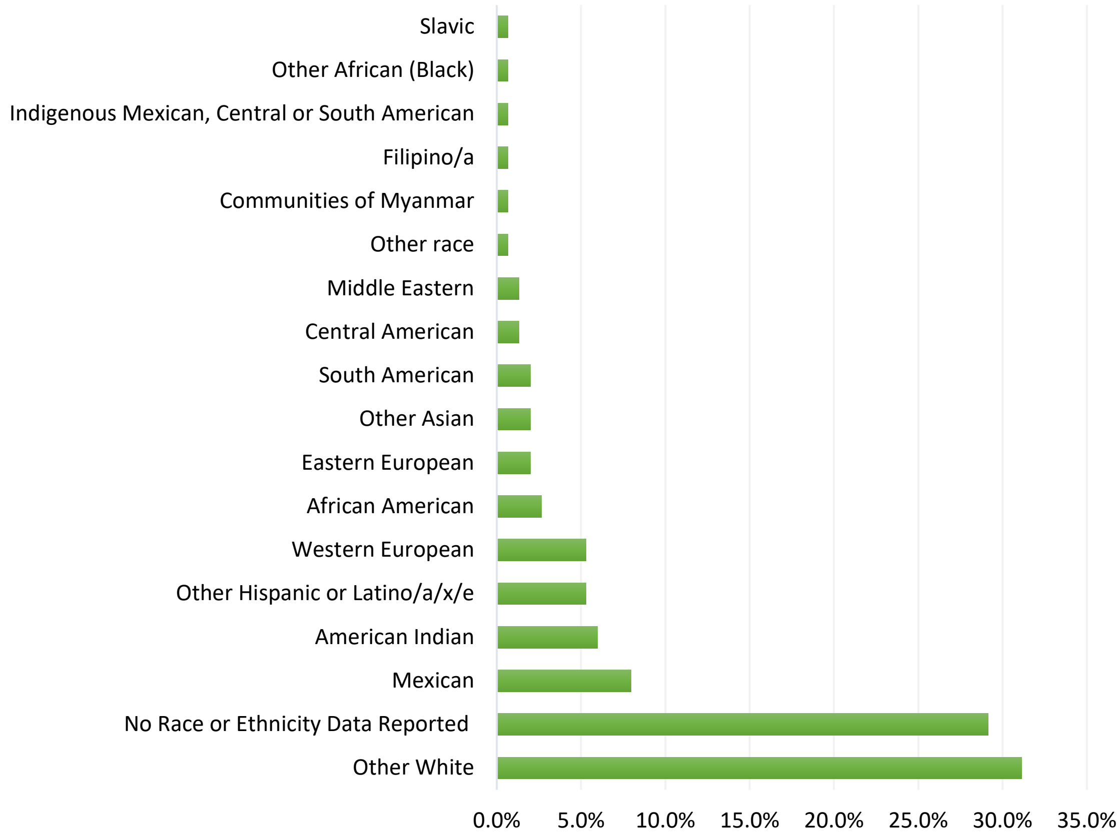
Table 2. The PMPM and Emergency Department (ED) utilization for diabetes and behavioral health/ mental health conditions

	IHN-CCO Adult Members		**IHN-CCO Adult Members living in BHH location (Lebanon)**	
	Average PMPM per member	Average ED visits per member	Average PMPM per member	Average ED visits per member
All IHN-CCO Members 2023	$542	0.4	$665	0.5
IHN-CCO members with Diabetes	$1,559	0.8	$1,513	0.8
Diabetes + SUD + Mental Health Condition	$3,188	2.3	$3,314	2.2
Diabetes and/or SUD or Mental Health Condition	$1,939	1.3	$1,910	1.3
Mental Health Condition	$868	0.7	$883	0.8
SUD	$1,166	1.0	$1,281	0.9
Mental Health and SUD	$1,457	1.3	$1,432	1.1

REALD/SOGI assessment for adult IHN-CCO members living in Lebanon (Behavioral Health Home service region) with diabetes and comorbidities or SUD and/or mental illness.

Approximately 40 percent of the population for the Behavioral Health Home project identify as white, with 29 percent of the population's race being unknown. **Figure 1.** has the race and ethnicity broken down by specific racial/ethnic identity. As noted, most members identify as white with the second and third largest populations being Mexican and American Indian or Alaska Native. **Table 3.** shows that members in the target population who identify as white have the lowest average PMPM. Members who identify as American Indian or Alaska Native have substantially higher average PMPM (over $5,000 average PMPM) and average ED utilization (average of 2.2 ED visits). Members who identify as Hispanic or Latinx also have a higher average ED utilization rate.

Figure 1. Race and ethnicity reported for Behavioral Health Home target population



Target population: *IHN-CCO adult members living in Lebanon with Diabetes who have a substance use disorder (SUD) and/or mental health condition (MHC) who are assigned to a Samaritan Medical Clinic.*

Table 3. The average per member per month 2023 health care costs for the Behavioral Health Home target population by race and ethnicity group		
	Average PMPM	Average ED Utilization
Total target population	$1,948	1.2
White	$1,554	1.2
Asian	$1,403	1.2
Black/African American	$1,932	1.2
Hispanic or Latinx	$1,861	1.8
American Indian and Alaska Native	$5,102	2.7
*Other/More than one race	– –	– –
No Race or Ethnicity Data	$1,991	0.75

*data too small to report
Cost and ED data may be different from Table 1. Table 3 only includes members who are assigned to a Samaritan Medical Clinic, Table 1. Includes all adult members who adult IHN members living in Lebanon

Over 86 percent of the target population report speaking English and 8.6 percent do not have language data reported. For those who report a language other than English, the languages include Spanish or "other". Some of the members also report American Sign Language as their form of communication. No disparities were identified by language, but the project will be monitoring access to OHA certified or qualified health care interpreters to ensure language does not become a barrier. All members report being cisgender, with 8.6 percent of the target population not having data reported for gender identity. Approximately 17.2 percent of the target population report having a disability. Those with a known disability do have slightly higher ED utilization, but their PMPM costs were about 39 percent higher when compared to those in the target population without a disability.

Sexual Orientation data are unavailable. IHN-CCO is currently working on accomplishing the requirements outlined in House Bill 2359 to ensure the data collection of REALD/SOGI on IHN-CCO members is updated annually. A REALD/SOGI survey is being established using OHA approved data collection tools. Once approved by OHA the survey will be used to collect and report sexual orientation data. The data will be integrated into IHN-CCO data warehouse to ensure data are segmented by REALD/SOGI for the effective assessment of disparities.

D. Brief narrative description

The Behavioral Health Home pilot aims to unite community partners to provide a comprehensive, person-centered approach for individuals with both physical and mental health/behavioral health needs. This collaborative effort spans across the continuum of care and involves IHN-CCO, primary care, community-based organizations, as well as mental health and substance use disorder recovery service partners. The target population are IHN-CCO members ages 18 and older who reside in East Linn County (Lebanon) and are assigned to a Samaritan Medical Clinic. The member must have a diagnosis of diabetes as well as a comorbidity of SUD and/or mental illness to be included in the target population. This means the people in the target populations could have:

- Co-occurring diabetes, SUD, and mental illness; or
- Co-occurring SUD and diabetes, but no mental health condition; or
- Co-occurring diabetes and mental illness, but no SUD.

SUD is defined as members who have two claims over a two-year period with diagnosis codes for alcohol use disorder, opioid use disorder, and/or other drug disorders. Mental health conditions/illness are defined as members with two or more claims over a two-year period with diagnosis codes for anxiety disorder, depressive disorders, PTSD, schizophrenia or other psychological disorders, bipolar disorder, and/or personality disorders. Diabetes is defined as those with two or more claims for type 1 or type 2 diabetes.

How the project is integrating Behavioral Health.

Samaritan Medical Group (SMG) primary care, in conjunction with their mental health and behavioral health departments, collaborates with IHN-CCO, Linn County Mental Health, and C.H.A.N.C.E. recovery support services to establish workflows and structures for the Behavioral Health Home in Lebanon. The pilot seeks to enhance health outcomes, reduce healthcare costs, and enhance member engagement for individuals outlined in the target population by integrating behavioral health and primary care. The clinic adopts a team-based approach tailored to IHN-CCO members in the target population. Draft staffing models comprise care coordination, Peer Delivered Services, Health Educators, and Certified Alcohol and Drug Counselors (CADC), and primary care providers. Different staffing models are being assessed, but the staffing model favored by the team is one that

includes the Behavioral Health provider as the primary care provider. This would allow the Behavioral Health provider to better integrate the member's SUD and/or mental health condition into their overall care plan by being the first to establish care.

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

Activity 1 description: Establish EMR and data infrastructure to measurement the WHOQOL-BREF (World Health Organization Quality of Life (QoL) - BREF) questionnaire to assess the QoL of patients at two key time points: enrollment and 10-12 months post-enrollment. The WHOQOL-BREF is a validated instrument designed to measure QoL across four domains: physical health, psychological health, social relationships, and environment. It consists of 26 questions and employs a five-point Likert scale for responses.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Build EMR and data infrastructure to evaluate the quality of life (QoL) of target population.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Data Infrastructure built.	A QoL data infrastructure is established and operationalized.	12/2024	Patient's QoL is measurable.	12/2025

Activity 2 description: Create sustainability for the Behavioral Health Home through value-based payment contracts.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Establish a value-based contract with the Behavioral Health Home clinic in Lebanon.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No Value-Based Payment contract is established.	Value-Based Payment contract is active between IHN-CCO and Lebanon Behavioral Health Home clinic.	03/2025	Lebanon Behavioral Health Home Clinic meets the metrics outlined in their value-based payment contract.	03/2028
Monitoring measure 2.2	Establish an MOU between all organizations involved in the Behavioral Health Home Clinic, including Samaritan Health Plan, Samaritan Health Services, Community Based SUD recovery services, and other community mental health partners.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No MOU is established	MOU is established between all	03/2025	MOU is evaluated and updated	03/2028

between Behavioral Health Home partners.	partners involved in supporting the Behavioral Health Home Clinic sustainability.		between partners and stakeholder on an annual basis.	

Activity 3 description: Equitably engage members across the continuum of care by integrating all of their physical, mental health, and behavioral health (recovery services) needs in one facility.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Reduce the average number of ED visits for IHN-CCO members living in Lebanon with co-occurring SUD, Diabetes, and Mental Health Condition.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average number of ED visits for target population is 2.2.	Average number of ED visits for target population is 2.0.	01/2026	Average number of ED visits for target population is 1.5.	01/2027
Monitoring measure 3.2	Reduce the PMPM health care costs for members of the target population who identify as Native American or Alaska Native, specifically members who identify as American Indian.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average PMPM for target population is $5,102 dollars.	The average PMPM costs will decrease by 3% (about $4,949 average PMPM.	01/2026	The average PMPM costs will decrease by 5% (about $4,847 average PMPM.	01/2027
Monitoring measure 3.3	Improve the percent of the target population who are in control of their HbA1c.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
32.8% of the target population are not in control of their HbA1c.	31.0% of the target population are in control of their HbA1c.	01/2026	29.0% of target population are in control of their HbA1c.	01/2027

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #2- Monitoring the competence of individuals providing language assistance to IHN-CCO members with an identified interpreter service need.

A. **Project title**: Monitoring the competence of individuals providing language assistance to IHN-CCO members with an identified interpreter service need.

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: CLAS standards.
2. Component 2 (if applicable): Health equity: Cultural responsiveness.
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? 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

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

Improving access to high quality health care interpreters.

As Oregon's population becomes more diverse, it has become critical to address how we effectively deliver health care services to members with disabilities and from diverse genders, sexual orientation, cultures, and linguistic backgrounds. Access to a qualified medical interpreter is fundamental for improving health equity. The American Community Survey concludes that in Oregon, about 15.3% of the population speaks a language other than English in their home. Having a professional medical interpreter at every aspect of the continuum of care supports the patient and provider relationship, lowers the risk of medical error and patient safety issues, can reduce readmission rates, and ensure equitable emotional support for the patient.[1] [2]

The CLAS standard number 7, *ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided,* was recognized as a key priority by the state of Oregon in the passing of House Bill 2359 into law. The House Bill requires all health care providers receiving public funds to use an Oregon Health Authority (OHA) certified or qualified health care interpreter (HCI) or a health care provider/worker who has passed an OHA approved language proficiency test. To aid in compliance of House Bill 2359, OHA established the Health Equity Measure: Meaningful Access to Health Care Services for persons with limited English proficiency. IHN-CCO has not met OHA standards outlined in the health equity measure since its creation in 2021. For MY2022 about four percent of IHN-CCO members with an identified interpreter service need outlined in the OHA hybrid data had an OHA certified or qualified health care interpreter (HCI). For MY2023, preliminary data show a worsening trend for IHN-CCO members accessing an OHA certified or qualified HCI. This performance is unacceptable. To improve, IHN-CCO needs to build a strong foundation for monitoring the competence of individuals providing language assistance.

Disparities in accessing OHA Certified or Qualified HCI.

The OHA hybrid sample for MY2023 assessed 1,630 IHN-CCO members with an identified interpreter service need who had a physical, mental/behavioral, and/or dental encounter. About 88 percent of the members in the sample had a reported language they speak at home. Members with American Sign Language needs and members who report speaking both Spanish and English had the most encounters with an OHA certified or qualified HCI. Members who report speaking Middle Eastern Languages (about 1.9% of encounters) such as Arabic, Dari, and Turkish had zero OHA certified or qualified HCI. Encounters needing an OHA certified or qualified HCI who speak an Asian language (about 2.1% of encounters), such as Chinese, Burmese, Korean, and/or Vietnamese also had zero qualifying encounters. Encounters for members speaking Spanish languages were reported most frequently (about 80.5% of encounters required a Spanish speaking HCI). The number of encounters with an OHA certified or qualified HCI was higher for this group but continues to be inadequate. About 1.4% of encounters required an OHA certified or qualified HCI who spoke a Mayan language. Less than half of the encounters for members who speak Mam received an OHA certified or qualified HCI.

About 10.8% of the encounters' gender identity was unknown. All encounters with gender identity were cisgender. Around 12.5 percent of encounters reported having a known disability. Members who report being deaf or hard of hearing had an OHA certified or qualified HCI most frequently. Access to an OHA certified or qualified HCI when reviewed by race was inadequate among all identified races and ethnicities. Sexual orientation data are unavailable. A project for collecting sexual orientation data is outlined in IHN-CCO Health Equity Plan. Once the data is collected from member's access to OHA certified or qualified HCI access will be assessed by sexual orientation as well.

Moving Forward.

The overall system failure to provide OHA certified or qualified HCIs makes it difficult to outline specific gaps in care or disparities by REALD/GI because all groups are showing limited access to certified or qualified health care interpreters. Steps were taken in 2023 to improve the monitoring of qualified HCIs and support the collection of the health equity measure data. Those steps included: 1) Contracted with interpreter service vendors who have OHA certified or qualified HCI that providers can utilize at no cost to their organization; 2) Reduce the administrative burden of collecting the required data for each encounter by having the IHN-CCO contracted interpreter service vendor complete the submission. 3) Establish value-based payment bonus for providers to ensure all members with an interpreter service need are receiving an OHA certified or qualified HCI; and 4) Established a language service webpage for providers serving IHN-CCO members that includes information on our contracted vendors, FAQs, and additional resources for providers such as the OARs and provider trainings.

Previous projects in the CLAS TQS focus area aimed to improve access to interpreter services for specific areas of the IHN-CCO system, such as evaluating HCI access at clinics where a high percentage of their patients were limited English proficient. To have the ability to assess the competence of individuals providing language assistance, a broader approach needs to be established to evaluate the system as whole for providing an OHA certified or qualified HCI. Once this is accomplished gaps in care and disparities in accessing qualified interpreter services can be formally addressed.

D. Brief narrative description.

Improving the monitoring of the competence of individuals providing language assistance.

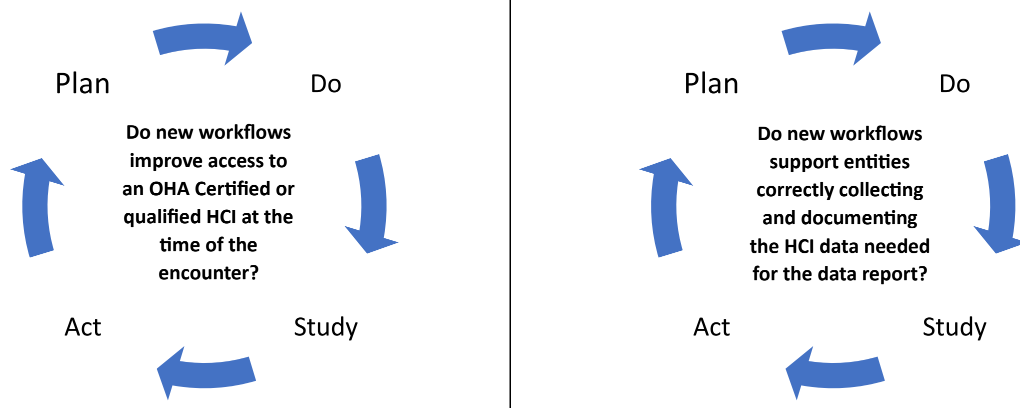
2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

The TQS project will focus on CLAS standard 7. The target population are IHN-CCO members ages 5 and older with an interpreter service need flagged in MMIS or if the member lists a specific interpreter need on their 834 that is not flagged in MMIS. The purpose of the project is to establish a single interpreter services monitoring report that includes the denominator data collected by IHN-CCO and the numerator data collected and reported by provider groups and contracted HCI service vendors. This transformative project aims to remove barriers for IHN-CCO members access to culturally and linguistically responsive care by aligning data collection and reporting for IHN-CCO contracted provider groups and HCI vendors. The project supports IHN-CCO's movement towards a health care delivery system that improves equitable access to care, help people with interpreter service needs effectively engage in their care, and reduce the risk of error due to inadequate interpreter services.

The project surrounds building a combined interpreter services monitoring report with both numerator and denominator data (denominator: encounters with an interpreter service need; numerator: if the encounter received an interpreter service by an OHA certified or qualified interpreter or a provider who passed an OHA approved language proficiency test) that can be used to assess inequities in accessing OHA certified or qualified HCI by place of service and member REALD/SOGI components. To effectively build the report, IHN-CCO will need to improve numerator data collection from HCI vendors and provider groups. The project will complete the following to reach the goal having an interpreter services monitoring report to monitor the competence of interpreter services in the IHN-CCO service area:

- Document HCI vendor and contracted provider organization workflows for accessing a certified or qualified health care interpreter at the time of the appointment.
- Document HCI vendor and contracted provider organization workflows for collecting and reporting the health equity numerator data needed to match the IHN-CCO denominator report.
- Conduct SWOT analysis on current workflow to identify gaps and opportunities to grow.
- Opportunities to grow identified in the SWOT analysis will be infiltrated into the workflows and tested using a PDSA cycle (example in **Figure 1.**).

Figure 1. PDSA cycle example



IHN-CCO has established a team of quality and health outcomes staff, contracting, and IS teams to support the implementation of the project. The quality and health outcomes team is working 1:1 with providers groups and the HCI vendors to document the workflows, complete the SWOT analyses and accomplish the PDSA projects. The

IS team is responsible for configuring the interpreter services monitoring report and ensuring the data sent from provider groups and HCI services vendors has less than 5 percent error. Contracting monitors the relationships with the HCI service vendors. If any aspects arise in the PDSA cycles, such as additional data the vendors will need to collect to support the interpreter services monitoring report, contracting will be responsible for updating this information in the HCI vendors contracts.

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

Activity 1 description: Ensure the data submitted for the interpreter services monitoring report has less than 5% error by establishing quality improve projects focused on improving data collection and accessing OHA certified or qualified health care interpreters with IHN-CCO contracted HCI service vendors and provider groups who are contracted with IHN-CCO.

☒ Short term or ☐ Long term

Monitoring measure 1.1	All IHN-CCO contracted interpreter service vendors and a minimum of three contracted provider groups agree to participate in a PDSA cycle to assess their health equity measure workflows.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No workflows are documented on how *entities aim to meet the health equity measure.	Workflows are documented for participating entities.	01/2025	PDSA cycle is complete on entity's workflows to evaluate effectiveness.	01/2026
Monitoring measure 1.1	Development of a Health Equity Data report with combined numerator and denominator data.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Health Equity data report has significant numerator data errors.	Health Equity data report has < 8% numerator data reporting error.	07/2025	Health Equity data report has < 5% numerator data reporting error.	01/2026

*entities are defined as IHN-CCO HCI contracted vendors and IHN-CCO contracted provider groups.

Activity 2 description: IHN-CCO can effectively assess the competence of language services for members with limited English proficiency by establishing an interpreter services monitoring report for assessing access to OHA certified and qualified HCI by location, age, type of service, and REALD/SOGI.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Development of a Health Equity Data report with combined numerator and denominator data.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Health Equity data report has significant numerator data errors.	Health Equity data report has < 8% numerator data reporting error.	07/2025	Health Equity data report has < 5% numerator data reporting error.	01/2026
Monitoring measure 2.2	REALD and SOGI data are integrated into the interpreter service monitoring report.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No REALD/SOGI data, in accordance with House Bill 2359, are integrated into the interpreter services monitoring report.	Member surveys will be sent to IHN-CCO members using OHA approve REALD/SOGI data collection tools and data are integrated into the data warehouse to be pulled for the interpreter services monitoring report.	01/2026	REALD and SOGI data are included in the interpreter services monitoring report to assess disparities.	1/2027

Activity 3 description: Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided, by utilizing the interpreter services monitoring report.

Monitoring measure 2.2	IHN-CCO equitably improves access to OHA certified or qualified HCI for people with an interpreter service need registered in MMIS.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
IHN-CCO did not meet their improvement target for MY2023.	IHN-CCO will meet their improvement target.	01/2026	IHN-CCO will meet their improvement target annually.	1/2027

2024 OHA Transformation and Quality Strategy (TQS)

CCO: InterCommunity Health Network - IHN-CCO

Project #3- Community Led Behavioral Health Intervention Models

A. **Project title:** Community Led Behavioral Health Intervention Models

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**

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

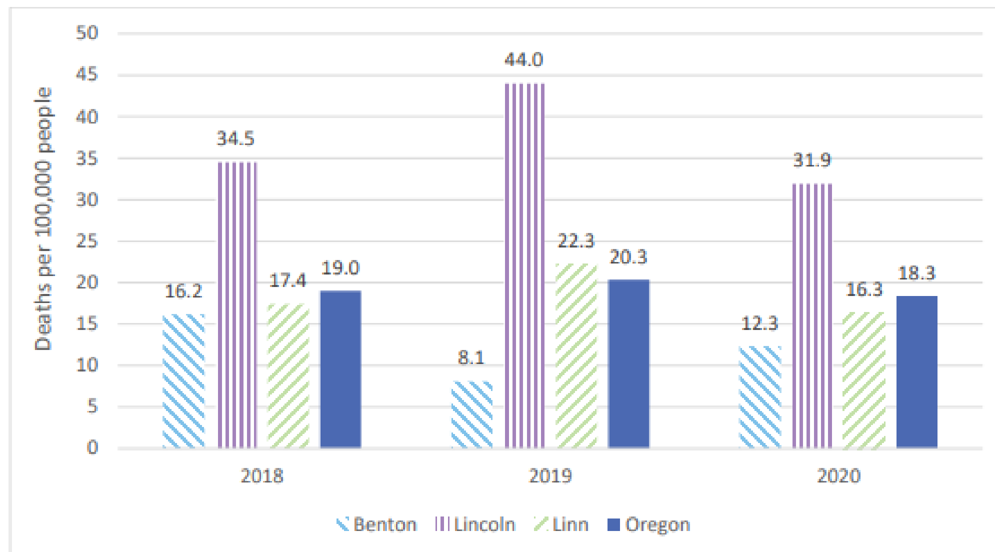
C. **Project context:** Complete the relevant section depending on whether the project is new or continued.

High-risk and under-resourced communities have reached out to request the development of culturally responsive, equitable programs designed to provide focused support and navigation in a system that is often hostile. In addition to clearly identifying the need for such support services, these communities have also pointed towards potential solutions that are both innovative and driven by lived experience.

Communities that face elevated levels of health inequities and health disparities may be perceived as high-risk, and while there is a myriad of data that clearly illuminates adverse health outcomes for these communities, resiliency, community-building and development of mutual aid networks, and depth of invaluable lived experience is often overlooked. When it comes to navigating a system that is unfamiliar, often unaffirming, and not always set up to meet the needs of marginalized communities, the mental and emotional impact of that process may result in harm, care avoidance, or poorer health outcomes – aside from experiences that may take place within the context of direct services. Culturally responsive services have been shown to help mitigate these impacts.

IHN-CCO's service area includes depression and suicide that are higher than the average rates in Oregon, including one of the highest suicide rates in the state in Lincoln County. Similarly, behavioral health encompasses four or the top five most common diagnoses for IHN-CCO members, with depression, anxiety, and SUD being some of the costliest conditions overall for IHN-CCO members. The building of culturally responsive, community led mental health programming is essential to the development of an effective response that addresses the ongoing systemic inequity, bias, and access challenges.

Figure 8-5: Age adjusted number of deaths by suicide per 100,000 people by year and location



Data source: Oregon Violent Death Dashboard
Time period: 2018-2020
For more information: https://www.oregon.gov/oha/PH/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx

The priority populations selected for this project were jointly supported by community feedback through our Community Advisory Council, Delivery System Transformation Committee, members' lived experiences, and a review of our Regional Health Assessment.

LGBTIQA2S+ Community with an emphasis on transgender and gender diverse communities:

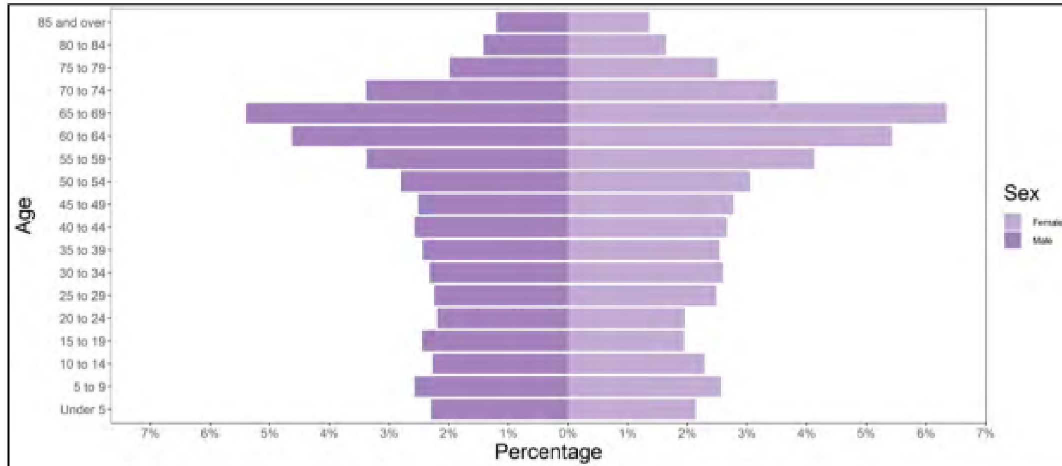
Recent national survey data demonstrated the extent of the mental health crisis for LGBTIQA2S+ youth in particular with over 40% of Oregon youth surveyed indicating suicidal thoughts, a rate that rose to 54% for nonbinary and trans youth[1]. Regional advocates spoke to the need for expanded programming beyond traditional peer support that includes health navigation, advocacy within medical systems, and affirming partnership.

Older Adults:

The World Health Organization found that globally over a quarter (27.2%) of suicides occur in people over the age of 60[2] while in the US there has been a 13% rise in senior suicides in the last decade. People of Color and people in rural areas had the highest increases, with 'significant increases in suicide death rates in rural areas'[3]. Lincoln County Oregon has a substantially older population than other areas of the IHN-CCO region as well as a notably high suicide rate[4]. These factors, combined with community feedback, indicated that mental health interventions led by peers could benefit both the mental and physical health of that community. While Lincoln County's high suicide rate is not driven by the senior population, there is potential that lessons learned from the model may inform future interventions.

[1] The-Trevor-Project-2022-National-Survey-on-LGBTQ-Youth-Mental-Health-by-State-Oregon.pdf (thetrevorproject.org)
[2] Mental health of older adults (who.int)
[3] A Look at the Latest Suicide Data and Change Over the Last Decade | KFF
[4] 2022 Regional Health Assessment (ihntogether.org)

Figure 2-4: Population pyramid for Lincoln County



Data source: United States Census Bureau, America Community Survey, Table B01001
Time period: 2016-2020
For more information: https://data.census.gov/cedsci/

Table 6-2: Number of deaths per 100,000 people by leading causes of death and location

Cause of Death	Benton	Lincoln	Linn	Oregon
Malignant neoplasms (cancer)	152.1	356.1	253.7	194.2
Diseases of the heart	138.4	262.9	262.3	172.7
Cerebrovascular diseases	35.9	66.3	94.3	52.4
Accidents (unintentional injuries)	34.9	105.6	72.3	57.8
Alzheimer Disease	34.9	39.3	44.0	47.1
Diabetes mellitus	21.1	72.5	33.0	31.8
Chronic lower respiratory diseases	18.0	76.6	51.1	46.1
Chronic liver disease and cirrhosis	12.7	43.5	22.0	19.5
COVID-19	10.6	29.0	27.5	33.6
Essential hypertension and hypertensive renal disease	10.6	24.8	24.3	15.8
Intentional self-harm (suicide)	9.5	29.0	17.3	19.6

Data source: OHA Center for Health Statistics
Time period: 2020
For more information: https://visual-data.dhsoha.state.or.us/t/OHA/views/CountyDash/CountyDash_cause

Houseless Individuals with Disabilities:

Individuals with disabilities, particularly IDD have high risk of co-occurring mental health conditions and have been poorly served by the traditional mental health system[5]. SAMSHA recommends the utilization of a Bio-

[5] Persons With Intellectual and Developmental Disabilities in the Mental Health System: Part 1. Clinical Considerations | Psychiatric Services (psychiatryonline.org)

Psycho-Social model to address the behavioral and social determinants of health needs of this high-risk population[6]. The IHN-CCO region includes higher than average disability rates, including both cognitive and ambulatory disabilities[7] and recognizing the high levels of disability in the unhoused community, a partnership was proposed to assess peer led programming at a daytime use and outreach center that works with unhoused individuals.

Table 2-7: Percent of population per age group with disability by location

Age	Benton	Lincoln	Linn	Oregon
Under 5 years	0.4%	0.0%	0.0%	0.7%
5 to 17 years	4.8%	7.9%	7.0%	6.2%
18 to 34 years	7.6%	12.9%	11.3%	8.4%
35 to 64 years	10.5%	22.2%	17.1%	13.6%
65 to 74 years	18.4%	30.1%	31.1%	26.0%
75 years and over	42.9%	51.4%	51.7%	49.6%

Data source: United States Census Bureau, America Community Survey, Table S1810
Time period: 2016-2020
For more information: https://data.census.gov/cedsci/

D. Brief narrative description

The populations being addressed for the TQS Community Led Behavioral Health Intervention Models are:

- LGBTQIA2S+ community, with an emphasis on transgender and gender diverse communities.
- Older adults.
- Houseless individuals and those facing housing insecurity.
- Disability community.

While the project focuses on these four populations, it is imperative to note the diverse intersecting identities that many individuals within these communities have. This list is not exhaustive, nor does it capture the complex and layered identities that individuals within these populations may have.

Peer Delivered Services (PDS) provide a model for the integration of community-based services into Oregon's Medicaid Traditional Health Worker payment model. However, existing models are primarily reactive, and treatment focused, and the need has been identified for a proactive, preventative model of PDS as a health equity focused approach to individual and community health. Currently, both formal and informal community-based programming exists to provide support, guidance, and leadership navigating health systems. The development of

[6] PowerPoint Presentation (nasmhpd.org)
[7] 2022 Regional Health Assessment (ihntogether.org)

OHA approved Traditional Health Worker (THW) programming would provide a sustainable model for CCO partnerships with leaders in underserved communities.

IHN-CCO Engagement & Transformation team will be providing collaborative, administrative support for community-led program development of a model of PDS that focuses on prevention rather than treatment; on resilience rather than pathology, showing leadership among CCOs. By providing resources for the development of a cohort of peers from communities with high levels of health inequities and higher risk of mental health diagnoses, including the LGBTQIA2S+ community, seniors, houseless folks, and persons with disabilities, will be an innovative step forward in providing culturally competent services that meet community-identified needs in a manner that is consistent with honoring communities' ability to take ownership in defining their own wellness.

Project Structure:

The first phase of this work will focus on developing the scope of work. Identified community partner organizations will meet at a self-determined cadence to explore community needs, identify community-informed strategies, and develop measurable goals and outcomes. A community-identified coordinator will support materials development (e.g., agendas, minutes, etc.), schedule meetings, follow up with workgroup members as needed, and report on workgroup-developed metrics.

Project Process:

In keeping this work genuinely informed by community need, it is integral that community is intentionally involved at the ground level. This includes working collaboratively to define roles and build a scope of work, giving community decision making power, and ensuring that the course of this work is shaped by and responsive to those with lived experience. IHN-CCO will provide funding to three community partner organizations who are both representative of and serve one or more marginalized communities. Utilizing a non-hierarchical, collaborative approach, IHN-CCO will support this group as needed, but will be mindful to not dictate any aspect of the work. Meetings between IHN-CCO and identified community partners will begin in January 2024. Community members with intersecting identities often face additional health disparities, as the layered and overlapping facets of their lives place them at the crossroads of varying systems of oppression and institutional violence. As such, collaborating with organizations led by and/or serving folks with diverse, intersecting identities will not only better reflect the diversity of IHN-CCO members, but also lend invaluable lived experience and community perspectives to this work, which would be of great benefit to members receiving these support services.

Future State of Project:

Ultimately, the long-term goal is for a group of peers to provide direct support services to subpopulations of IHN-CCO members whose unique needs may be unmet by current models of Peer Delivered Services. However, the final outcome of this idea will be shaped by the culturally specific partner organizations that develop the scope of work. Generally speaking, the idea is that through combining professional training with lived experience and community knowledge, these set of peers would build meaningful relationships, assist in resource and healthcare system navigation, provide comprehensive case management, and serve as a key touchpoint between the member and their provider(s).

In addition to direct service, a critical piece of the peers' roles could reside in conducting meaningful outreach to providers and community-based organizations with the intention of increasing resource awareness and fostering relationships. Furthermore, peers will engage with their communities to develop trusting relationships, familiarity,

and build a growing knowledge base of current issues and needs. In this way, referrals can occur organically, and community-based data can be utilized to directly inform equitable decision making and program growth.

The central tenant of this model is that it is responsive and adaptive to community needs. Should challenges or barriers arise, the communities being served would be regarded as key stakeholders and decision-makers in developing strategies and creative solutions to move forward. This may include inviting community members to sit on pertinent steering committees, work groups, or participate in other decision-making spaces where their input would be not only welcomed but centered and valued. As an innovative model of peer delivered services, this pilot has the potential to be both scalable and replicable. This may take shape through developing a technical assistance or learning model open to community-based organizations that would like to take the next step in growing non-traditional, prevention and positive health-focused peer delivered service models into their work, or through sharing challenges and successes regarding the pilot to other CCOs.

E. Activities and monitoring for performance improvement.

Activity 1 description: Understand the target population's need for mental health supports by establishing relationships with community partners who work directly with the target population(s)

☒ Short term or ☐ Long term

Monitoring measure 1.1	Partner organizations who serve the target population will engage in the TQS project.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No community partnership is established to support understanding the target population's need.	Partnerships are established with organizations who serve the following communities: LGBTQIA2S+ (with an emphasis on transgender and gender diverse communities); Older adults; Houseless and insecure housing individuals; Disability community.	01/2025	Community partners have documentation outlining each specific population's mental health needs.	07/2025
Monitoring measure 1.2	Partner organizations who serve the target population will identify a project coordination to be dedicated to the TQS project.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No project coordinators are assigned.	Each participating organization will have one project	01/2025	The assigned coordinator will drive each	01/2025

	coordinator assigned to the TQS project.		designated sites project.	

Activity 2 description: Support a community driven project focusing on improving the target population's mental health resources by establishing a scope of work for each target population.

☐ Short term or ☒ Long term

Monitoring measure 2.1	A scope of work (i.e., action plan with SMARTIE goals) will be developed by partner organizations that includes targeted goals and objectives for improving each population's (LGBTQIA2S+, Older adults, Houseless and insecure housing individuals, Disability community) mental health resources.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Collaboration to complete the scope of work is not occurring.	Project coordinators will convene to establish the scope of work.	12/2025	SMARTIE goals are established within the scope of work.	07/2025
Scope of work is not implemented.	Action plans are established by project coordinators to implement the scope of work.	01/2026	Community partners begin implementing their designated action plans within the scope of work.	01/2027

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #4- Oral health integration at behavioral health facilities

A. **Project title:** Oral health integration at behavioral health facilities

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: 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.

Heavy alcohol use, methamphetamine, cocaine, and opioid use significantly impact oral health outcomes. Feedback from IHN-CCO Dental Care Organizations (DCO) indicates people with substance use disorder (SUD) are difficult to engage in oral health services and have a high no-show rate. Anecdotally, the evidence demonstrates that IHN-CCO members with SUD are hesitant to visit the dentist due to anxiety and trauma, embarrassment because of the current state of their oral health, being stigmatized or shamed for having SUD, and fear of the cost of care due to not understanding their dental benefits. IHN-CCO established a focused measure in the DCO's value-based payment contract to support access to oral health services for people with SUD; however, in 2023 only 28.3 percent of people with a diagnosis of SUD had an oral health service.

Table 1. has the percentage of IHN-CCO members with an SUD diagnosis by racial and ethnic identity. Most members with SUD identify as white. When reviewing disparities by race and ethnicity, members who are Native American or Alaska Native have the lowest oral health service utilization compared to other race and ethnic populations.

Table 1. IHN-CCO members with substance use disorder who had an oral health service by race and ethnicity.

White	Eastern European	41.9%
	Middle Eastern	
	North Africanand	
	Other White	
	Slavic	
	Western European	
Asian, Pacific Islander, and/or Native Hawaiian	Asian Indian	5.5%
	Cambodian	
	CHamoru (Chamorro)	
	Chinese	
	Communities of Micronesian Region	

	Communities of Myanmar	
	Filipino/a	
	Japanese	
	Marshallese	
	Native Hawaiian	
	Other Asian	
	Other Pacific Islander	
	Samoan	
	Vietnamese	
Black/African American	African American	2.4%
	Afro-Caribbean	
	Other African (Black)	
	Other Black	
Hispanic or Latinx	Central American	13.7%
	Mexican	
	Other Hispanic or Latino/a/x/e	
	South American	
Native American or Alaska Native	Alaska Native	3.2%
	American Indian	
	Indigenous Mexican, Central or South American	
Other Race / Multiple Races	Other race	1.7%
Race Unknown		31.6%

When reviewing IHN-CCO members with SUD by language, most members report speaking English only. About 1.2 percent report other languages including Vietnamese, German, Spanish, and Russian. The numbers are small, but there are disparities present by preferred language. Members with SUD who speak English complete their annual oral health services at a higher rate than members who report a language other than English. About 17.3 percent of the population with SUD had a known disability. The most prevalent disability were people who reported having a limitation but who can live independently or care for themselves. The percentage of members with an SUD diagnosis and a disability who had an oral health service in 2023 (27.2%) was slightly lower than people with no disability (28.2%); however, the difference in uptake is minimal. Less than 1 percent of IHN-CCO members with a diagnosis of SUD were not cisgender. This includes members who identify as transgender or non-binary. About 12.9 percent of the population's gender identity is unknown. The small numbers make it difficult to measure disparities, but oral health services were provided to people with SUD who identify as transgender or non-binary. To ensure equity, potential disparities among this population will need continued assessment.

D. Brief narrative description

Previous oral health integration projects focused on integrating oral health services at primary care settings, such as improving access to fluoride varnish in primary care clinics and supporting HbA1c testing at oral health facilities

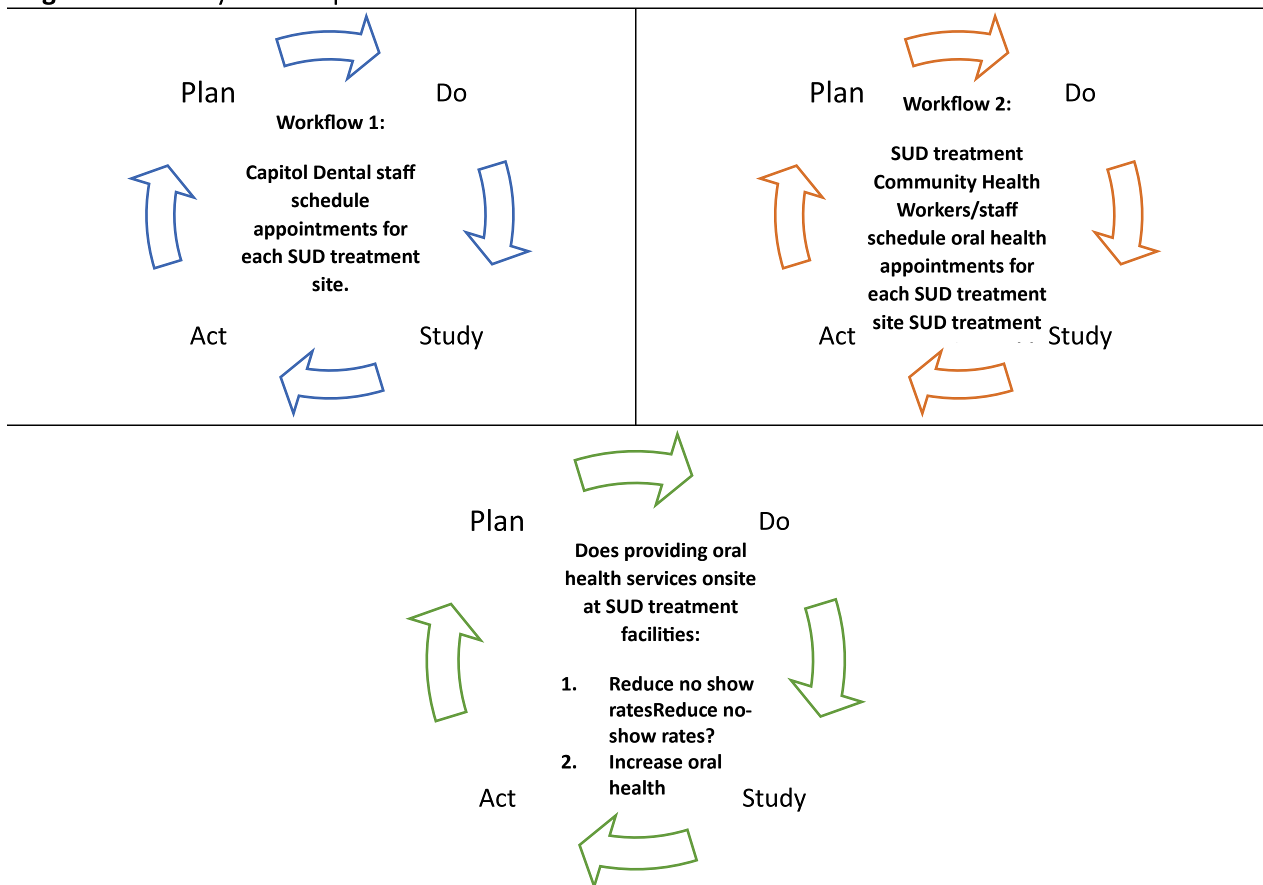
for people with diabetes. For the current oral health integration TQS project, IHN-CCO will evaluate the integration of oral health services at Substance Use Disorder (SUD) treatment facilities with the goal of improving oral health service utilization for people with SUD. The target population are IHN-CCO members with a diagnosis of substance use disorder, including alcohol use disorder, opioid use disorder, and other drug use disorder (diagnosis codes that fall into the initiation and engagement HEDIS measure). Three SUD treatment facilities agreed to participate in the pilot program: Lincoln County Health and Human Services, Linn County Alcohol and Drug, and ReConnections Counseling. These SUD treatment facilities were chosen because they have the highest number of claims for SUD treatment for IHN-CCO members over a six-month period. The DCO partnering with the SUD treatment facilities is Capitol Dental. Capitol Dental is the largest DCO in IHN-CCO service region (over 60% of IHN-CCO membership is assigned to Capitol Dental). Capitol Dental has a dental van and portable dental equipment that can be transported to the SUD treatment facilities. The goal is to provide oral health services at each SUD treatment facility once a quarter (equals a total of 24 hours of time spent per quarter providing oral health services at the three SUD treatment sites).

Roles and Responsibilities		
IHN-CCO	**Capitol Dental**	**Participating SUD treatment facilities**
• Ensure Capitol Dental has an updated gap list for their SUD and oral health measure to conduct outreach and schedule appointments with members at the appropriate SUD facilities. • Track project implementation efforts and support DCO and SUD facilities with implementation barriers. • Establish an evaluation plan.	• Schedule appointments with IHN-CCO members at one of the participating SUD treatment facilities. • Transport and set up dental equipment at each SUD treatment facility. ○ Provide a full day of dental services once a month at each participating SUD facility location. • Provide the following services to IHN-CCO members at the SUD treatment facility. ○ Oral Health Assessments. ○ X-rays. ○ Intraoral photos. ○ Sealants. ○ Fluoride varnish. ○ Silver diamine fluoride. ○ Teeth cleanings. ○ Periodontal therapy services. ○ Oral hygiene instruction, education, and supplies,	• Have a room available for Capitol Dental staff to set up dental equipment and privately see patients. • Provide a check-in and waiting area for patients. • Help market access to oral health services with their clients to reduce no shows. • Schedule oral health appointments (select facilities).

	such as toothbrushes, and toothpaste. ○ Restorative and emergent services as available: Examinations, fillings, or extractions.	

Two PDSA cycles will be completed to evaluate the best workflow for improving engagement in oral health services at the SUD treatment sites (see **Figure 1.** for an example). A third PDSA will be completed to evaluate the benefits of having oral health integration at SUD treatment facilities.

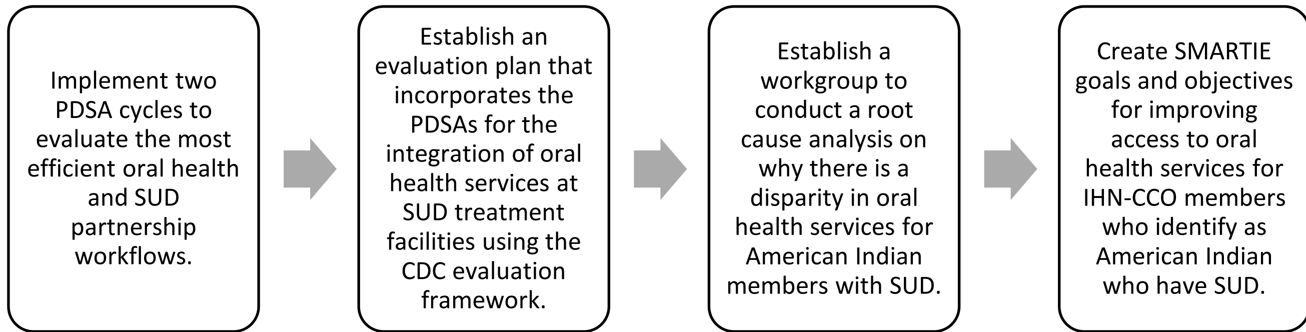
Figure 1. PDSA cycle example.



The REALD/SOGI analysis identified disparities in oral health utilization among members who identify as American Indian. To support equitable access to oral health services, quality and health outcomes staff will partner with IHN-CCO tribal liaison and Health Equity Liaison staff, SUD treatment partners, and oral health partners to conduct a Root Cause Analysis. The goal of the Root Cause Analysis is 1) Identify the underlying cause(s) for why there is such a large disparity in accessing oral health services for American Indian IHN-CCO members; 2) Establish root causes that are in IHN-CCO's control to change and/or improve on; and 3) Establish a precise SMARTIE goal(s) for removing disparities in oral health screenings among American Indian IHN-CCO members with SUD.

For year one, the desired outputs are outlined in **Figure 2.**

Figure 2. The outputs IHN-CCO expects to accomplish in year one of the oral health integration TQS project.



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

Activity 1 description: Evaluation plans will be established using the PDSA format for understanding the impact of integrating oral health services at SUD treatment facilities.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Evaluation plans will be documented using the PDSA format for each research question.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No evaluation plans are documented.	Evaluation plans are documented for each research question using the PDSA format.	01/2025	Research questions are tested and studied using the PDSA format.	01/2026

Activity 2 description: Integrating oral health services at SUD treatment facilities to improve oral health service utilization for IHN-CCO members with SUD.

☐ Short term or ☒ Long term

Monitoring measure 2.1	The oral health service utilization rate for IHN-CCO members with SUD			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
28% of IHN-CCO members with SUD had an oral health service in 2023.	30% of IHN-CCO members with SUD have an oral health service completed.	01/2026	35% of IHN-CCO members with SUD have an oral health service completed.	01/2027

Activity 3 description: Reduce the oral health service disparity for IHN-CCO members who identify as American Indian or Alaska Native by partnering with IHN-CCO Tribal liaison and SUD treatment facilities who support American Indian and Alaska Native populations to review potential barriers for the population (i.e., cultural barriers, transportation, or access barriers, etc.).

☐ Short term or ☒ Long term

Monitoring measure 3.1	Assess barriers for accessing oral health services for IHN-CCO members with SUD who are identify as Native American or Alaska Native			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
23.4% of IHN-CCO members with SUD who identify as American Indian or Alaska Native had an oral health service in 2023 (21% lower than the total IHN-CCO population).	Oral health screening disparity between Native American or Alaska Native populations will reduce by 3%.	01/2026	31.1% of IHN-CCO members who identify as American Indian with an SUD diagnosis have an oral health service.	01/2027

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #5- Supporting PCPCH Member Enrollment

A. **Project title:** Supporting PCPCH Member Enrollment

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

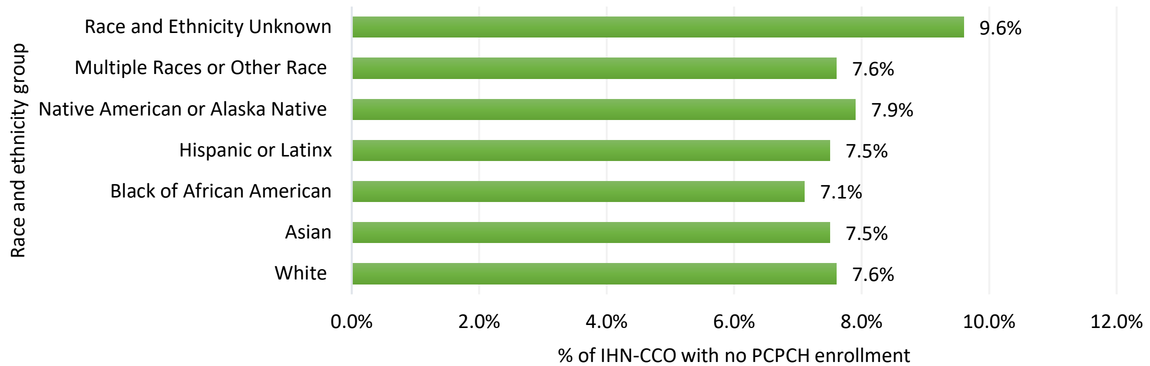
1. Component 1: PCPCH: Member enrollment.
2. Component 2 (if applicable): Choose an item.
3. Component 3 (if applicable): Choose an item..
4. Does this include aspects of health information technology? ☐ Yes ☒ No
5. If this is a CLAS standards project, which standard does it primarily address? Choose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

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

IHN-CCO did not meet the Patient-Center Primary Care Homes (PCPCH) member enrollment requirements for 2022 and 2023. Ensuring IHN-CCO members have equitable access to a PCPCH is a high priority for IHN-CCO because PCPCH's support the patients' health by enhancing care coordination services, supporting transitions of care, increasing access to care, and improving member engagement. Approximately 8.1% of IHN-CCO members are not assigned to a PCPCH recognized clinic. There are specific disparities in PCPCH enrollment when reviewed by county of residence, age, race and ethnicity, language, disability, and gender identity.

The IHN-CCO service region serves Benton, Lincoln, and Linn Counties. Benton County houses most of the health services, as well as community-based services that support health outcomes. Non-PCPCH enrollment is much lower in Benton County (8.3%) compared to Lincoln (16.2%) and Linn (15.2%) Counties. When reviewed by age, IHN-CCO members ages 18-24 have the lowest PCPCH enrollment rate (9.4%). General race profiles show minimal disparities in PCPCH enrollment, as shown in **Figure 1.**; however, reviewed by specific race and ethnic identity, PCPCH enrollment disparities are present among members who identify as Cambodian (28% non-PCPCH enrollment), Communities of Myanmar (10.3% non-PCPCH enrollment), and Ethiopian (20% non-PCPCH enrollment). About 1% of the non-PCPCH enrolled members are one of the following gender identities: transgender, non-binary, both genderfluid and/or genderqueer (could include other identities), multiple genders but not genderfluid or genderqueer, agender/no gender, and/or questioning. The largest disparity in PCPCH enrollment was among people who are transgender (9.1% non-PCPCH enrollment). About 17.3% of IHN-CCO members report having a disability. Of those with a disability, 7.5% are not enrolled in a PCPCH. Enrollment in PCPCH was similar when reviewed by preferred language, but members who report speaking Russian/Ukrainian had slightly lower PCPCH enrollment.

Figure 1. The percent of IHN-CCO members who are not assigned to a PCPCH by race and ethnicity.



Sexual Orientation data is unavailable. IHN-CCO is currently working on accomplishing the requirements outlined in House Bill 2359 to ensure the data collection of REALD/SOGI on IHN-CCO members is updated annually. A REALD/SOGI survey is being established using OHA approved data collection tools. Once approved by OHA the survey will be used to collect and report sexual orientation data. The data will be integrated into IHN-CCO data warehouse to ensure data are segmented by REALD/SOGI for the effective assessment of disparities.

D. Brief narrative description

The following TQS project will focus on improving PCPCH enrollment for all IHN-CCO members no matter their age, location, or REALD/SOGI. A SWOT analysis was conducted to understand the current gaps and opportunities to improve.

Strengths

- Data infrastructure for assessing inequities in PCPCH enrollment.
- Positive internal partnerships between enrollment department and quality and health outcomes team.

Weaknesses

- PCPCH enrollment systems are not operationalized.
- Documentation and workflows for assigning members to a PCPCH are not up-to-date or are non-existent.
- A high percent of members' REALD/SOGI demographics are unknown.
- There are disparities in PCPCH enrollment.

Opportunities to Grow

- Standardizing how IHN-CCO members are equitably enrolled in PCPCH – including documenting workflows and creating policies and/or procedures.
- Training all staff on the process for equitably enrolling IHN-CCO members into a PCPCH.
- Creating a sustainability plan to ensure PCPCH enrollment is prioritized and equitable.

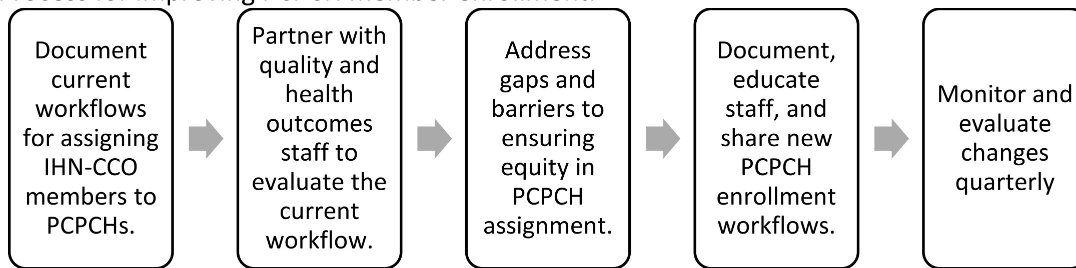
Threats

- High staff turnover in enrollment department.
- Silos within the enrollment team and external departments.

- Evaluate PCPCH enrollment on a quarterly basis by REALD/SOGI to ensure zero disparities in PCPCH enrollment.

IHN-CCO enrollment and quality and health outcomes departments will partner to conduct a PDSA (Plan, Do, Study, Act) cycle for establishing, implementing, and evaluating the PCPCH enrollment process (example in **Figure 2.**)

Figure 2. Process for improving PCPCH member enrollment.



Once enrollment and quality and health outcomes staff have evaluated the PCPCH workflow, the final process will be sent to the Quality Improvement Committee (QIC). Once the QIC members have collectively approved the process, the PCPCH enrollment process will be operationalized. When a process is operationalized, formal department policies and processes/procedures are established. IHN-CCO reviews policies and procedures on an annual basis to ensure the process and policy are up-to-date and effective. In addition, PCPCH enrollment will be evaluated biannually at the QIC meeting to ensure there are zero REALD/SOGI disparities in PCPCH enrollment.

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

Activity 1 description: PCPCH enrollment is operationalized by establishing effective workflows that include health equity components.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Document PCPCH enrollment workflows.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No documentation.	Workflows are documented.	01/2025	Workflows complete a PDSA cycle and are approved by QIC.	01/2026
Monitoring measure 1.2	REALD/SOGI PCPCH enrollment disparities are eliminated.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

No PCPCH enrollment workflow addresses health equity.	PCPCH workflows include health equity components.	01/2025	No disparities in REALD/SOGI are present in PCPCH enrollment.	01/2026

Activity 2 description: IHN-CCO meets OHA's PCPCH enrollment threshold by operationalizing PCPCH enrollment strategies.

☐ Short term or ☒ Long term

Monitoring measure 2.1	IHN-CCO meets OHA PCPCH enrollment threshold.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Did not meet OHA PCPCH enrollment threshold.	Meets OHA PCPCH enrollment threshold.	01/2026	IHN-CCO consistently meets/exceeds OHA PCPCH enrollment threshold.	01/2027

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #6- Supporting PCPCH Tier Advancement

A. Project title: Supporting PCPCH Tier Advancement

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

If continued, insert unique project ID from OHA: 436

B. Components addressed.

1. Component 1: PCPCH: Tier advancement.
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.

IHN-CCO's previous years' efforts included engaged Creach Consulting Group, LLC to provide TA in support of evidence-based PCPCH tier advancement, integrate traditional health workers, and help clinics achieve fidelity-based integrated behavioral health services. This was offered to PCPs by IHN-CCO at no cost. Throughout 2022 and parts of 2023, Creach Consulting Group, LLC, continued to provide consultation, TA, and coaching to develop and support evidence based PCPCH services at primary care clinics. This consists of the following activities: Conducting a follow-up survey on engagement activities with PCP clinics; Providing additional resources and support for the process of PCPCH recognition, application renewal, and site visits; Providing Traditional Health Worker and Behavioral Health Integration support; Providing consultation on managing metrics gap lists; and Obtaining consultation related to enhancing VBP agreements.

In 2023 PCPCH tier advancement results were:

- One Level 2.
- Three Level 3.
- 86 Level 4.
- 20 Level 5.
- 1 Clinic remained a Level 2.
- All Level 3 clinics remained at a level 3.
- 10 of the Level 4 clinics increased to a Level 5.
- Level 5 clinics remained at Level 5.

IHN-CCO met its goal of 5 PCPCH's at tier 3 or lower as evidenced by 4 providers being level 2 or level 3. **Table 1.** outlines the monitoring measures for 2023 and the outcome.

Table 1. Results of 2023 PCPCH Tier Advancement Project Monitoring Measures.

Monitoring Measures	Measure Outcome	Mitigation Efforts/Changes for 2024
The percent of IHN-CCO members covered under a tiered PCPCH.	Not Met – IHN-CCO did not meet OHA's PCPCH enrollment threshold for 2023.	IHN-CCO is building a TQS PCPCH member enrollment project to review the current process for enrolling members into a PCPCH.

The percent of IHN members under an at-risk PCP VBP.	Met – IHN-CCO has worked diligently to get our PCP clinics into a risk based VBP (PCP).	IHN-CCO continues to improve our value-based contracting initiatives by establishing a value-based payment contract committee who reviews contracts for value-based payment approval.
PCPCH Tier Advancement	Met - IHN-CCO met their goal for supporting clinics PCPCH tier advancement for 2023.	Moving forward, IHN-CCO will support clinics who did not advance in 2023 and need additional supports.
PCP TA Evaluation	Met - Survey initiated.	N/A
PCP Consultation Engagement	Not Met – IHN-CCO had a goal of 10% engagement with PCP clinic network. IHN-CCO has a network of 110 PCP Clinics. At year end of 2023 outreach and engagement through our consultant occurred with 11 clinics. This is a rate of 9% engagement. IHN-CCO did not meet their goal of 10% provider engagement.	As this goal was not met in 2023 a shift in resources has changed causing a shift in the direction of IHN-CCO PCPCH tier advancement engagement strategy. Moving forward IHN-CCO will use internal resources to provide focused provider engagement and support for PCPCH tier advancement.

Creach Consulting Group, LLC., is no longer a partner with IHN-CCO due to an end to the contractual relationship. Moving forward IHN-CCO will establish internal pathways for engaging with providers for enhancing PCPCH tier advancement. IHN-CCO will use lessons learned and best practices to develop strong relationships and increase engagement to meet PCPCH tier advancement goals.

D. Brief narrative description

The PCPCH project consists of two main components: 1) Target one or two practices and work with them to apply for Tier 5 PCPCH recognition; and 2.) Continued on-going support of providers who are actively engaged in PCPCH tier advancement.

Target area 1:

IHN-CCO provider network and contracting staff will continue to provide support and monitoring of PCPCH activities to help provider clinics advance in their PCPCH tier advancement journey. Monthly meetings will be established with specific clinics (Valley Clinics and Lincoln County Health and Human services) to discuss their quality measures for their VBP scorecards. During these meetings the clinical staff will be engaged regarding their technical assistance needs for PCPCH tier advancement. The technical assistance needs will be documented, and action plans will be developed by the provider network and contracting team on how to support the clinics with their tier advancement.

2024 OHA Transformation and Quality Strategy (TQS)

CCO: InterCommunity Health Network - IHN-CCO

Target area 2:

Target area two focuses on ongoing support for actively engaged PCPCHs who want to improve their tier advancement or sustain their current tier. These providers also have routine monthly and/or quarterly checking with quality and health outcomes staff and provider network and contracting. Their specific goals for PCPCH tier advancement will be documented and outlined during these meetings in 2024 to clearly understand their needs for improving or sustaining their current PCPCH level status.

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

Activity 1 description: Support tier advancement for Valley Clinics and Lincoln County Health and Human Services.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Support tier advancement for Valley Clinics and Lincoln County FQHC.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
IHN-CCO is currently not engaging the two identified clinics for this project in tier advancement from level 4 to level 5.	IHN-CCO will actively engage with clinics outlined to increase PCPCH tier status from level 4 to level 5.	07/2025	Administer future consults to monitor PCPCH tier 5 status.	01/2026
Monitoring measure 1.2	Provide ongoing support for clinics for PCPCH tier advancement.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9% of PCP clinics in IHN-CCO's PCP clinic network were engaged in PCPCH tier advancement consultation and engagement.	IHN-CCO will provide support and engagement to 10% of PCP clinics in IHN-CCO's PCP clinic network.	01/2026	IHN-CCO will provide support and engagement to 15% of PCP clinics in IHN-CCO's PCP clinic network.	01/2027.

Project #7- Nurture Oregon: Supporting Pregnant People with Substance Use Disorder and Mental Health Conditions

A. **Project title:** Nurture Oregon: Supporting Pregnant People with Substance Use Disorder and Mental Health Conditions

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: 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.

Morbidity and Mortality Risks for Pregnant people with Substance Use Disorder and/or Mental Illness.

Pregnant people with substance use disorders (SUD) and/or Mental Illness (MI) are at higher risk during their prenatal and postpartum periods for the following: having a newborn who is preterm, low birthweight, or stillborn; newborn having fetal alcohol spectrum disorders or neonatal abstinence syndrome; child taken into DHS custody; self-harm during pregnancy and postpartum; death by suicide, suicidal ideation, or overdose; and unable to establish a positive parent child bond/relationship with their newborn. The Oregon Maternal Mortality and Morbidity Review Committee 2023 Biennial Report states that SUD and MI were the leading underlining causes of maternal mortality in Oregon. In 2023 there were 906 identified pregnancies among IHN-CCO members. Of those pregnancies about 31.6 percent had a known SUD or mental health condition.

Assessment of disparities in the rate of pregnant IHN-CCO members with SUD by REALD/SOGI.

When reviewing disparities among the pregnancies in 2023 for IHN-CCO members with SUD and/or MI, the data shows disparities by race and ethnicity and gender identity. **Table 1.** has the percent of IHN-CCO members with a pregnancy in 2023 with SUD and/or MI by race and ethnicity. Those who identify as American Indian had the highest rate of SUD and/or MI.

Table 1. The percent of IHN-CCO members with SUD and/or MI with an identified pregnancy in 2023.	
Race and ethnicity for pregnant IHN-CCO members with SUD and/or MI.	% of members with SUD and/or MI by race and ethnicity.
White	**61.6%**
Eastern European	--
Other White	--
Slavic	--

Western European	--
Asian, Pacific Islander, and/or Native Hawaiian	**37.5%**
Asian Indian	--
Filipino/a	--
Japanese	--
Native Hawaiian	--
Other Asian	--
Other Pacific Islander	--
***Black or African American**	**38.9%**
Mexican, Central or South American, Hispanic or Latinx	**24.7%**
Central American	--
Mexican	--
Other Hispanic or Latino/a/x/e	--
Indigenous Mexican, Central or South American	--
American Indian	**78.1%**
***Other Race**	**47.4%**
***Multiple Races**	**50.0%**
***Race Unknown**	**57.7%**

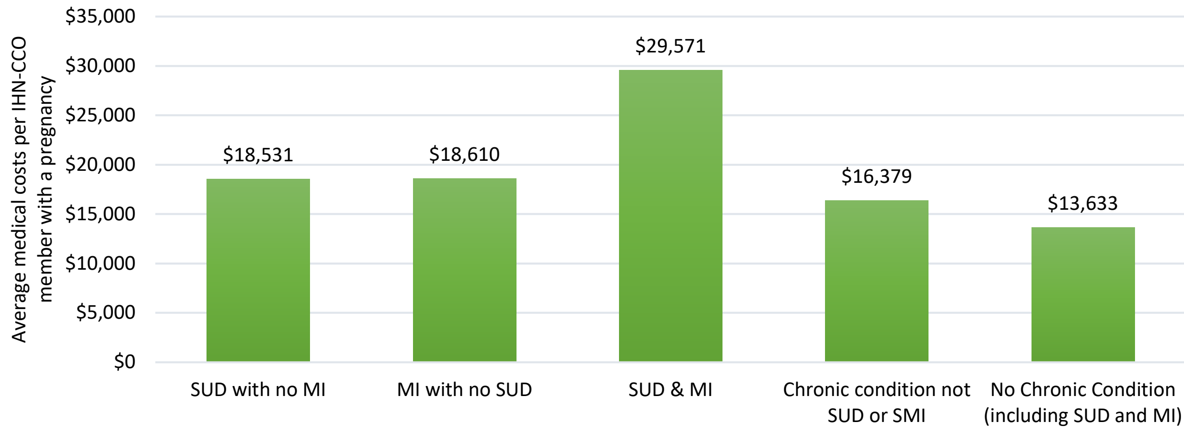
Approximately 95.6% of the pregnancies with SUD and/or MI had a recorded language. About 2.3 percent of pregnancies with SUD and/or MI reported speaking a language other than English. The languages other than English were Spanish, Spanish and English, other language (a language other than the languages presented on the survey), and another language not including sign language. Members with a language other than English had a lower prevalence of SUD and/or MI. About 17.0 percent of pregnancies reported a form of disability. For pregnancies with an SUD and/or MI diagnoses, 15.2% report having a disability or limitation. This is about 49 percent higher than pregnancies without SUD and/or MI. For all 906 pregnancies recorded in 2023, 97% report identifying as cisgender. Almost all pregnancies who identify as a gender other than the one they were assigned at birth (multiple genders, but not genderfluid or genderqueer, nonbinary, or transgender) had an identified SUD and/or MI.

Sexual Orientation data are unavailable. IHN-CCO is currently working on accomplishing the requirements outlined in House Bill 2359 to ensure the data collection of REALD/SOGI on IHN-CCO members is updated annually. An REALD/SOGI survey is being established using OHA approved data collection tools. Once approved by OHA the survey will be used to collect and report sexual orientation data. The data will be integrated into IHN-CCO's data warehouse to ensure data are segmented by REALD/SOGI for the effective assessment of disparities.

Health Cost and Utilization Disparities for Pregnant IHN-CCO members with SUD.

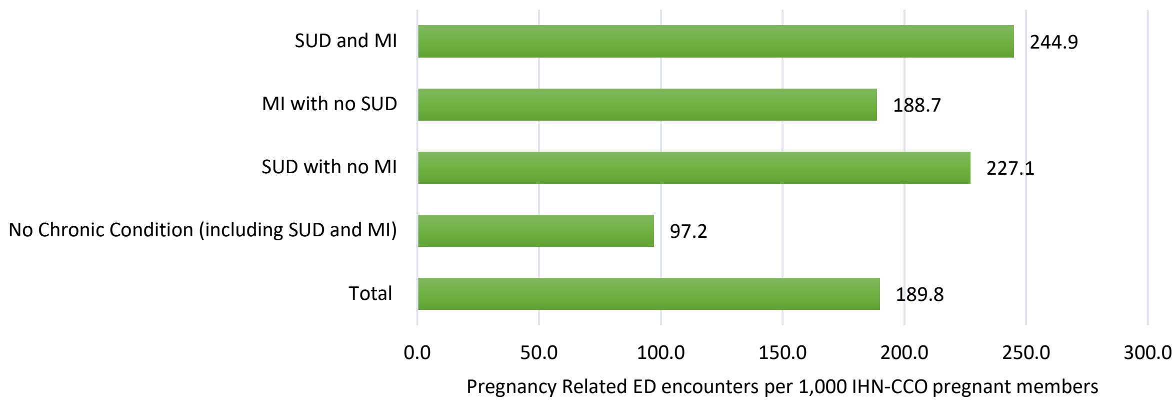
About 98 members with a pregnancy in 2023 had co-occurring SUD and MI. In 2023 the average medical costs per IHN-CCO member with an identified pregnancy was $13,767 dollars. The average medical costs increased by 114 percent for pregnancies with a co-occurring SUD and MI (see **Figure 1.**). The data in **Figure 2.** has the pregnancy related Emergency Department (ED) encounters for the 906 identified pregnancies in 2023. Members with SUD and those with SUD and co-occurring MI had the highest pregnancy related ED visits in 2023.

Figure 1. The medical costs for people who were pregnant in 2023 by SUD and MI status



Data Notes: Only members with continuous enrollment were included in the cost analysis. Cost data were available for 844 pregnant members in 2023, about 93% of the 2023 pregnancy population. Sample sizes: SUD with no MI n = 54; MI with no SUD n = 229; SUD & MI n = 98; Chronic Condition no SUD or SMI n = 145; No SUD or SMI and no chronic condition n = 281.

Figure 2. The rate of pregnancy related Emergency Department (ED) visits per 1,000 IHN-CCO members with a pregnancy in 2023 by SUD and MI status



Data Notes: Data includes IHN-CCO members who were eligible at any time in 2023 with a pregnancy recorded through claims. Arcadia Analytics utilization reports were used and filtered for a primary diagnosis of pregnancy and the Puerperium.

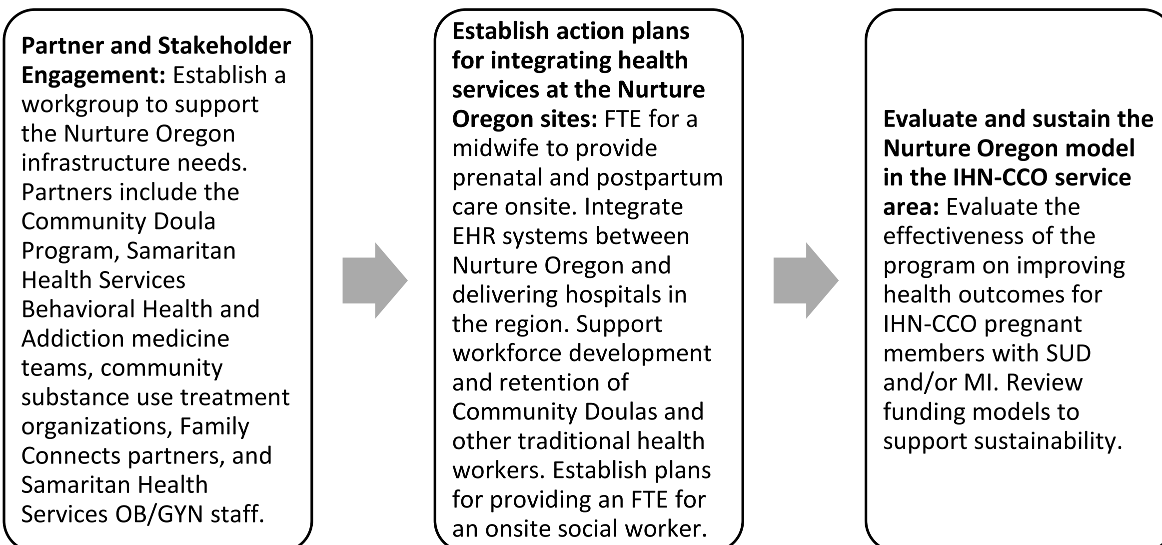
D. Brief narrative description

The purpose of the TQS project is to improve health outcomes and quality of life, reduce health care spending, and improve member engagement in health services for IHN-CCO members with SUD and/or MI during their prenatal and postpartum period. The project will work to accomplish this by partnering with Nurture Oregon sites in Lincoln and Benton Counties. The target population are pregnant and postpartum (1-year after delivery) IHN-CCO members with an identified substance use disorder and/or mental health condition. Substance Use Disorder is defined as someone who has two or more claims in a two-year period for opioid use disorders, alcohol use disorders, and/or drug use disorders. A mental health condition is defined as people with a serious or persistent mental illness (as outlined in OAR 309-019-0225) or a lower-level mental health condition including generalized anxiety disorders and/or depressive disorders.

Nurture Oregon is an integrated care model that aims to provide pregnant people with SUD Wraparound services to support their pregnancy and postpartum journey. The model helps people with SUD access peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. The model is shown to decrease the following: reductions in child maltreatment, placement of children in foster care, and increases in both prenatal visits and maternal lengths-of-stay in the hospital for people who were pregnant and diagnosed as opioid dependent. The Multnomah County Nurture Oregon project was very successful, leading the Oregon Maternal Mortality and Morbidity Review Committee to recommend implementing Nurture Oregon integrated care models throughout the state to support pregnant and postpartum Oregonians with SUD.

There are currently two Nurture Oregon sites in the IHN-CCO region. One in Lincoln County and one in Benton County (Benton County site opened in early 2024). The purpose of the model is to create a safe space for pregnant people to come and receive all their health services in one place. Each agency is working to implement the Nurture Oregon model to fidelity. The Nurture Oregon sites in the area have access to peer support and Community Doulas. They also partnered with Reconnections Counseling to support members with recovery and mental health services. The Benton County site is beginning to serve pregnant people, but the Lincoln County Nurture Oregon site was part of the initial state implementation. Lincoln County has served about 44 people and 25 births. There continue to be barriers and challenges for each Nurture Oregon site as they work to implement the model to fidelity and sustain their work in the community. To enhance the Nurture Oregon infrastructure, IHN-CCO will support collaboration among partners and stakeholders and support sustainability of the program in the IHN-CCO service region. **Figure 3.** provides a high level review of the roles and responsibilities of IHN-CCO for this TQS project.

Figure 3. IHN-CCO role and responsibilities for Nurture Oregon project



The outputs IHN-CCO aim to accomplish in year 1 are:

- FTE approved and funded for each Nurture Oregon site in the region to have a midwife provide prenatal and postpartum services on-site.

- A system established to support the sharing of treatment plans for Nurture Oregon participants with birthing units/delivering hospitals.
- A focus group with Community Doula program staff, Nurture Oregon leaders, SHS OB/GYN, Substance Use Treatment service providers, IHN-CCO Health Equity Liaison, and IHN-CCO Tribal Liaison regarding the prevalence of SUD/Mental Illness during American Indian and Alaska Native pregnancies.
    - The goal will be to establish an action plan on how to ensure Nurture Oregon has culturally and linguistically responsive care to support IHN-CCO members who identify as American Indian or Alaska Native.

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

Activity 1 description: Implement the Nurture Oregon model to fidelity by sustaining FTE for a midwife, at the Nurture Oregon sites in Lincoln and Benton Counties.

☒ Short term or ☐ Long term

Monitoring measure 2.1	A minimum of 0.4 FTE will be established for a midwife at the Lincoln County Nurture Oregon Site.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No midwife established onsite at Nurture Oregon Lincoln County site.	Budget is approved for Mid-wife at Lincoln County Nurture Oregon site.	01/2025	Implement Midwife services for prenatal and postpartum care at Lincoln County Nurture Oregon site.	07/2025
Monitoring measure 2.2	A minimum of 0.4 FTE will be established for a midwife at the Benton County Nurture Oregon Site.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No midwife established onsite at Nurture Oregon Benton County site.	Budget is approved for Mid-wife at Benton County Nurture Oregon site.	01/2025	Midwife begins seeing patients for prenatal and postpartum care at Benton County Nurture Oregon site.	07/2025

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Activity 2 description: Improve health outcomes for pregnant people with SUD and/or Mental Illness by improving closed loop referrals to Nurture Oregon by provider groups and community organizations.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Reduce the rate of pregnancy related Emergency Department encounters for pregnant IHN-CCO members with co-occurring Substance Use Disorder and Mental Illness.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
244.9 pregnancy related Emergency Department encounters per 1,000 IHN-CCO pregnant members with co-occurring SUD and MI.	214.3 pregnancy related Emergency Department encounters per 1,000 IHN-CCO pregnant members with co-occurring SUD and MI.	01/2026	193.9 pregnancy related Emergency Department encounters per 1,000 IHN-CCO pregnant members with co-occurring SUD and MI.	01/2027
Monitoring measure 1.2	Increase the timeliness of postpartum care for pregnant IHN-CCO members with Substance Use Disorder (SUD).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
68.8% of IHN-CCO members with SUD had a timely postpartum visit MY2023.	75.0% of IHN-CCO members with SUD had a timely postpartum visit.	01/2026	88.3% of IHN-CCO members with SUD had a timely postpartum visit.	01/2027
Monitoring measure 1.3	Increase the timeliness of prenatal care for pregnant IHN-CCO members with Substance Use Disorder (SUD).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
78.1% percent of IHN-CCO members with SUD had a prenatal visit in MY2023.	81.4% percent of IHN-CCO members with SUD had a prenatal visit.	01/2026	85.1% percent of IHN-CCO members with SUD had a prenatal visit.	01/2027
Monitoring measure 1.4	Reduce the average medical costs per pregnant IHN-CCO member with co-occurring Substance Use Disorder and Mental Illness.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Average medical costs per IHN-CCO members with co-occurring SUD and MI were $29,571 for 2023.	1.5% decrease in the average medical costs per pregnant IHN-CCO member with co-occurring SUD and MI.	01/2026	3.0% decrease in medical costs per pregnant IHN-CCO member with co-occurring SUD and MI.	01/2027

Activity 3 description: Ensure all members have prenatal and postpartum supports that are culturally appropriate for their identified race or ethnicity, or their gender identity by partnering with the community doula program and Reconnections Counseling to support the recruitment and training needs for doulas and peer support specialists.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Review the demographic characteristics of community doulas and peer support specialists providing care at the Benton County and Lincoln County Nurture Oregon sites.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Demographic characteristics unknown.	Peer support specialists and Community Doulas are comfortable providing their demographic characteristics to ensure equity.	01/2025	Community Doula and Peer support specialists are comfortable providing their demographic data annually to support equity.	01/2026
Monitoring measure 3.2	Understand the training needs of Nurture Oregon staff for providing culturally and linguistically appropriate care to IHN-CCO members with SUD and/or Mental Illness.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Training needs unknown.	A gap analysis is conducted to understand potential training needs of staff working with Nurture Oregon.	01/2025	Nurture Oregon requires identified training in the gap analysis for staff on an annual basis to support.	01/2026

Activity 5 description: The Nurture Oregon program is sustained in the IHN-CCO service region by creating financial partnerships between IHN-CCO and Samaritan Health Services.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Establish a sustainability plan to fund Nurture Oregon in Benton and Lincoln Counties.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No sustainability plan is established.	Funding streams are reviewed and evaluated to support sustainability (i.e., contracting with	01/2025	A sustainability avenue is identified, and a sustainability plan is established.	01/2026

	IHN-CCO, support through partnerships with Samaritan Health System).			

2024 OHA Transformation and Quality Strategy (TQS)
CCO: InterCommunity Health Network - IHN-CCO

Project #8- Under Pressure: Managing High Blood Pressure to Decrease Morbidity and Mortality Risk

A. **Project title:** Under Pressure: Managing High Blood Pressure to Decrease Morbidity and Mortality Risk

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

If continued, insert unique project ID from OHA: 510

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.

Project Update – Supporting D-SNP members with Hypertension control their blood pressure.

In 2023, the SHCN Dual eligible TQS project aimed to support members who are enrolled in Medicaid and Medicare (D-SNP members) decrease their risk of morbidity and mortality by providing additional support for those with hypertension. Partnerships were established with Samaritan Health System Ambulatory Pharmacy team to introduce additional care coordination by outpatient pharmacists for D-SNP members who are not in control of their blood pressure. The project was more difficult to implement than expected. There were a variety of data barriers that made it difficult for the SHS ambulatory team to effectively engage with the D-SNP members.

IHN-CCO shared with the SHS team data on D-SNP members with hypertension, including members who were in poor control of their blood pressure. The problem arose because members were getting their blood pressure tested multiple times and at multiple facilities. The population health platform IHN-CCO utilizes to assess blood pressure poor control, updates the member's blood pressure with each new reading. The members could have good control of their blood pressure, but they had a single blood pressure reading where it was not in control. As a result, the SHS ambulatory pharmacy team would connect with the member who had a poor blood pressure reading, and the member would communicate that they have good blood pressure, that their last reading was in the Emergency Department or in the hospital setting, resulting in a higher reading than normal. To mitigate this, IHN-CCO attempted to work with the system to obtain a report including the last three blood pressure readings for D-SNP members, but the IS team was unable to obtain previous readings. Other mitigation strategies included having the SHS ambulatory pharmacy team support D-SNP members who are not adherent to their hypertension medications; however, the data confirmed that D-SNP members with hypertension medication had very high adherence rates, resulting in only a few members for the SHS ambulatory pharmacy team to manage.

A variety of evidence concludes that partnerships between pharmacists and medical care helps people manage their hypertension, as well as engaging patients in care, and cultivating interdepartmental care between pharmacy teams and medical providers. Given the impact the project can have on D-SNP members with

hypertension, it was decided to move forward with the project, but change how the target population is identified.

The table below outlines the monitoring measures established in 2023 and progress to date.

Table 1. Result of monitoring measures and lessons learned in year one of the D-SNP hypertension project.

Monitoring Measure	Outcome	How IHN-CCO plans to meet the measure moving forward
DSNP cohort members ages 18-85 with hypertension are adherent to their RAS antagonist medication.	Met – 92% of members are adherent to their RAS antagonist medication.	Given the variety of barriers working with the population, we concluded medication adherence is not an issue among the population. The monitoring measures will be removed from the project.
DSNP cohort members with a condition history of hypertension are in-control of their blood pressure (<140/90).	Not Met - 2023 HEDIS data confirm that 70.8% of D-SNP members have a blood pressure that is in-control (<140/90). The goal was that 80 percent of members would be in control of their blood pressure.	The measures will continue to be evaluated but will not be the basis of identifying the target population. The goal of 80% in control is also too high and a more realistic goal will be established.
DSNP cohort members with a condition history of hypertension have a completed Heath Risk Assessment (HRA). DSNP cohort members with a condition history of hypertension have a completed Individualized Care Plan (ICP) and an Interdisciplinary Care Team (ICT).	Not met – the coordination between SHS ambulatory pharmacy team and IHN-CCO care coordination teams was not accomplished. Due to this, supporting the uptake of HRAs and ICPs were not prioritized among the SHS ambulatory pharmacy team.	IHN-CCO will prioritize establishing workflows between the SHS ambulatory pharmacy team and care coordination to establish pathways for supporting members without an HRA or ICP completed.

Moving forward, IHN-CCO will continue to partner with the SHS ambulatory pharmacy team to support D-SNP members with hypertension to ensure they are in control of their blood pressure.

REALD/SOGI disparities in managing blood pressure.

Final HEDIS data for 2023 conclude that about 30.5 percent of D-SNP members have hypertension. Of those, 29.2 percent were not in control of their blood pressure. Blood pressure control was evaluated by race and ethnicity, language, disability, and gender identity. After review, gender identity did not have disparities because all D-SNP members with reported gender identity data reported being cisgender (less than 1% did not have gender identity data reported). The numbers were small, but large enough to understand disparities in blood pressure control by race and ethnicity, language, and disability.

Table 2. The race and ethnicity of D-SNP members with a diagnosis of hypertension.		
Race and Ethnicity Group	Specific Race or Ethnicity	% of D-SNP population with hypertension
White	Eastern European	45.7%
	Middle Eastern	
	Other White	
	Slavic	
	Western European	
Asian	Asian Indian	7.0%
	Cambodian	
	Chinese	
	Communities of Micronesian Region	
	Filipino/a	
	Japanese	
	Korean	
	Native Hawaiian	
	Other Asian	
	Other Pacific Islander	
	Vietnamese	
Black or African American	Ethiopian	2.5%
	Other African (Black)	
	Other Black	
	Somali	
Hispanic or Latinx	Mexican	14.0%
	Other Hispanic or Latino/a/x/e	
	South American	
Native American or Alaska Native	American Indian	2.1%
	Indigenous Mexican, Central or South American	

About 28 percent of D-SNP members did not have a race or ethnicity reported and a very small number identified as more than 1 race (<1%). Most members identify as white as outlined in **Table 2.** White populations had the best blood pressure control (23.4% not in control of their blood pressure). About 32.4 percent of members who identified as Hispanic or Latinx had poor control of their blood pressure. Members who identify as Asian, Native American, or Alaska Native, Black or African American had to be combined into a single group to assess disparities in blood pressure. The data shows blood pressure control is worse among these members compared to white populations (32.6% with poor blood pressure control).

Over 88 percent of D-SNP members with hypertension report speaking English. About 28% of members who report speaking English are in poor control of their BP. About half of members who report speaking a language other than English (such as Spanish or Russian) are not in control of their blood pressure. About 16.9% reported a disability. Of those members, 29 percent had poor control of their blood pressure, while 26 percent of members with no disability had poor control of their blood pressure.

Sexual Orientation data are unavailable. IHN-CCO is currently working on accomplishing the requirements outlined in House Bill 2359 to ensure the data collection of REALD/SOGI on IHN-CCO members is updated annually. An REALD/SOGI survey is being established using OHA approved data collection tools. Once approved by OHA the survey will be used to collect and report sexual orientation data. The data will be integrated into IHN-CCO's data warehouse to ensure data are segmented by REALD/SOGI for the effective assessment of disparities.

D. Brief narrative description

The purpose of the intervention continues to be to reduce the risk of morbidity and mortality for D-SNP members 18 and older with poor control of their hypertension. The intervention focuses on additional care coordination support for D-SNP members by the Samaritan Health System (SHS) Ambulatory Pharmacy Team. The pharmacist assigned to members in the cohort will initiate the following:

- Educate members on home blood pressure monitoring (home meters will be checked against clinic monitors to ensure accuracy).
- Medication plans and education will be established. Medications will be adjusted for optimal dosing and side effect profiles. Diabetes is included in the protocols because optimization of diabetes medications may, in some cases, help with blood pressure control as well (e.g., SGLT2 inhibitors).
- Appropriate labs will be ordered for the members and follow-up will occur as needed.
- Assessment of medication will be established to ensure no medication issues are identified (e.g., other medications worsening blood pressure control).
    - If medications are identified that are impacting a member's blood pressure control, the pharmacist will conduct a consultation with the ordering provider.
- Referrals to care coordination teams and other resources when additional social, economic, or environmental barriers surface (i.e., food insecurity, transportation issues, houselessness, SUD).

Pharmacists will track interventions, time spent with members and blood pressure control to evaluate if the D-SNP one-on-one mentorship with the clinical pharmacist is successful. Given the barriers identified throughout the first year and the disparities in blood pressure control among D-SNP members, the project intervention will continue to be the same; however, the cohort will be expanded and stratified for outreach. In addition, quality and health outcomes staff will share the disparity data with the SHS ambulatory pharmacy team, to ensure they understand the gap is blood pressure control by race and ethnicity and disability status.

The cohort outreach will be stratified due to the REALD/SOGI assessment showing cultural and linguistical disparities in blood pressure control, as well disparities in control between members with a disability. Eliminating disparities must be prioritized. In addition, **Table 3.** outlines the differences in health care cost for D-SNP members with hypertension by race and ethnicity, disability, and diabetes status. It is clear there are inequities among D-SNP members with hypertension when it comes to health care costs and blood pressure control.

Table 3. The cohort stratification of D-SNP member target population for initial outreach from SHS ambulatory pharmacy team.
Cohort 1: D-SNP members who do not identify as white with HEDIS data that confirms poor blood pressure control in the previous 12-months.
Cohort 2: D-SNP members with a known disability with HEDIS data that confirms poor blood pressure control in the previous 12-months.
Cohort 3: IHN-CCO members with co-occurring hypertension and diabetes.

Table 4. The average PMPM costs for the target population by specific population segmentation.

Population	Average PMPM health care costs in 2023	Disparity
D-SNP Members with hypertension who do not identify as white.	$3,638.64	64% higher than D-SNP members who identify as white.
D-SNP Members with hypertension with a known disability.	$3,581.56	34% higher than D-SNP members who do not have a disability.
D-SNP members with co-occurring Hypertension and Diabetes.	$3,560.41	77% higher than D-SNP members with hypertension, but no diabetes.

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

Activity 1 description: Improve blood pressure control for target population by stratifying the target population for one-on-one engagement by the SHS ambulatory pharmacy team by race and ethnicity, disability, and diabetes status.

☐ Short term or ☒ Long term

Monitoring measure 1.1	The target population in control of their blood pressure.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
70.8% of the target population are in control of their blood pressure.	73.7% of the target population are in control of their blood pressure.	01/2026	80% of the target population are in control of their blood pressure.	01/2027
Monitoring measure 1.2	Disparities in blood pressure control are reduced by race and ethnicity.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
67.5% of the target population who do not identify as white are in poor	70% of the target population who do not identify as white are in control	01/2026	73% of the target population who do not identify as white	01/2027

control of their blood pressure.	of their blood pressure.		are in control of their blood pressure.	
Monitoring measure 1.3	The average PMPM for the target population who do not identify as white decreases.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The average PMPM for target population who do not identify as white is $3,638.	The average PMPM for target population who do not identify as white decreases by 3% (about $3,529 average PMPM).	01/2026	The average PMPM for target population who do not identify as white decreases by 5% (about $3,347 average PMPM).	01/2027

Activity 2 description: Establish partnerships between IHN-CCO Care Coordination and SHS Ambulatory Pharmacy team to establish work plans for improving HRA and ICP completion among target population.

☒ Short term or ☐ Long term

Monitoring measure 2.1	DSNP cohort members with a condition history of hypertension have a completed Heath Risk Assessment (HRA).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
95.3% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).[i]	97% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).	01/2026	100% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).	01/2027
Monitoring measure 2.2	DSNP cohort members with a condition history of hypertension have a completed Individualized Care Plan (ICP) and an Interdisciplinary Care Team (ICT).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
81.5% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.[ii]	83% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.	01/2026	87% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.	01/2027

Activity 3 description: Establish partnerships between IHN-CCO Care Coordination and SHS Ambulatory Pharmacy team to establish work plans for improving HRA and ICP completion among target population.

☐ Short term or ☒ Long term

Monitoring measure 3.1	DSNP cohort members with a condition history of hypertension have a completed Heath Risk Assessment (HRA).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
95.3% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).[i]	97% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).	01/2026	100% of DSNP members with a condition history of hypertension have a completed Health Risk Assessment (HRA).	01/2027
Monitoring measure 3.2	DSNP cohort members with a condition history of hypertension have a completed Individualized Care Plan (ICP) and an Interdisciplinary Care Team (ICT).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
81.5% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.[ii]	83% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.	01/2026	100% of DSNP members with a condition history of hypertension have a completed Individualized Care Plan and an Interdisciplinary Care Team.	01/2027

Project #9- Improving Resources for IHN-CCO members with SPMI

A. Project title: Improving Resources for IHN-CCO 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

Component 1: Serious and persistent mental illness.
Component 2 (if applicable): Choose an item.
Component 3 (if applicable): Choose an item.
Does this include aspects of health information technology? ☐ Yes ☒ No
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.

Mental health service access crisis.

People with Serious and Persistent Mental Illness (SPMI) often have a high level of social determinant of health problems that impact their condition, such as stable housing, employment, stigma and discrimination, and access to healthcare.[1] IHN-CCO Care Coordination staff aim to enroll members with SPMI in behavioral health (BH) care coordination services. Care coordination supports members with SPMI mental and physical health needs, while also connecting them to specific community resources to support their housing, food, and/or employment needs.

IHN-CCO currently has nine BH care coordination staff. Three staff are dedicated to supporting Oregon State Hospital and Assertive Community Treatment members; however, all BH care coordination staff serve members with SPMI. Care coordination is currently receiving referrals from IHN-CCO Customer Service based on Health Risk Assessment screenings. individual providers, self-referrals from IHN-CCO members, IHN-CCO utilization team, and/or community partners. Once a member connects with a BH care coordinator, the coordinator conducts a needs assessment. Through this process the member's physical and mental health needs are assessed as well as their social, economic, and environmental needs.

Oregon is experiencing a mental health access crisis. The Center for Health Systems Effectiveness final 2022 report to the Oregon State Legislature disclosed the prevalence of mental health conditions among Oregon adults. The report discovered an increase in mental health diagnoses from 2008-2019, especially among Oregon adults ages 18 to 25; however, an increase in prevalence was not followed by significant rise in mental health services, resulting in 26.4% of the mental health needs being unmet for Oregon adults. The 2024 County Health Rankings displays the difference in the number of population to one mental health provider (see **Table 2.**). The ratio has improved from 2019 to 2023 across the state and within the IHN-CCO region. The data in **Table 2.** indicates that Lincoln and Linn counties both have lower access to mental health providers when compared to the state and Benton County.

Table 2. The ratio of population to mental health providers for IHN-CCO service region compared to the state, County Health Rankings, 2023.					
	Ratio of population to mental health providers				
Location	**2019**	**2020**	**2021**	**2022**	**2023**
Benton County	130:1	110:1	100:1	90:1	80:1
Lincoln County	260:1	230:1	220:1	210:1	200:1
Linn County	660:1	580:1	550:1	500:1	470:1
Oregon	210:1	190:1	180:1	170:1	160:1

Feedback from IHN-CCO members through the Community Advisory Council (CAC) was that the Emergency Department is being used to support the community's medical needs because they are having to wait months to see their primary care provider or access mental health services. After speaking with our Behavioral Health Care Coordinators, they are concerned about the time it takes for people with SPMI to access services to support their condition and/or social determinant of health needs. They report that members are playing a "waiting game" to access essential medical and community-based services. IHN-CCO Behavioral Health Care Coordinators aim to establish effective care plans for IHN-CCO members with SPMI; however, the wait to access the clinical and/or community-based services makes implementing the treatment plan difficult. Members become frustrated with the inability to have a timely appointment available to them, impacting their overall engagement in care coordination and the likelihood of completing the care plan care coordination establishes with the member.

Enrollment of IHN-CCO members with SPMI in Behavioral Health Care Coordination.

Of the 35,802 IHN-CCO members 18 and older who were continuously enrolled in 2023, approximately 14.4% had at least one of the following SPMI: Schizophrenia or other psychological conditions; Bipolar Disorder; Obsessive Compulsive Disorder (OCD); Post Traumatic Stress Disorder (PTSD); Reoccurring Major Depressive Disorder; and/or Schizotypal personality disorder. The most prevalent SPMI among the 5,149 IHN-CCO members was Major Depressive Disorder, closely followed by PTSD.

IHN-CCO members with a documented SPMI in 2023 report different racial and ethnic backgrounds. About 22.8 percent of the populations' race and ethnicity are unknown (this is being addressed in IHN-CCOs health equity plan on REALD/SOGI data collection). About 60 percent report being white. The second largest population are members who identify as Hispanic or Latinx (5.7%). The third highest racial group identify as Asian (2.4%). **Table 3.** breaks down each race and ethnicity profile identified for IHN-CCO members with an SPMI. Most members report speaking English (96.9%) and about 2 percent report speaking a language other than English, including Spanish or Russian/Ukrainian.

Table 3. The Race and Ethnicity of IHN-CCO members with SPMI.	
White	**60.1%**
• Eastern European • Middle Eastern • North African • Other White • Slavic • Western European	

Asian	**2.4%**
• Asian Indian • CHamoru (Chamorro) • Chinese • Communities of Micronesian Region • Filipino/a • Japanese • Korean • Native Hawaiian • Other Asian • Other Pacific Islander • Samoan • South Asian • Vietnamese	
African American	**1.4%**
• African American • Afro-Caribbean • Other African (Black) • Other Black	
Hispanic or Latinx	**5.7%**
• Central American • Mexican • Other Hispanic or Latino/a/x/e • South American	
Native American or American Indian	**4.1%**
• Alaska Native • American Indian • Canadian Inuit, Metis, or First Nation • Indigenous Mexican, Central or South American	
Other Race/Multiple Races	**3.2%**
• Other race • Multi (all)	
Race Unknown	**22.8%**

About 2.9% of the SPMI population identify as a different gender than the one assigned to them at birth, as shown in **Table 4.**

Table 4. The gender identity of IHN-CCO members with a recorded SPMI.

Gender Identity Category	Sex: Female	Sex: Male
Identify as a Boy/Man	1.0%	98.0%
Identify as a Girl/Woman	96.2%	0.6%
Multiple genders but not genderfluid or genderqueer	0.4%	0.2%
Non-Binary	1.1%	0.6%

Other Gender Identity	0.2%	0.0%
Gender Identity Unknown	1.1%	0.6%

About 53.4 percent of the SPMI population report a disability and/or limitation and 35 percent report not having a disability (11.6% do not have disability data recorded). Of members with SPMI who have a recorded disability, most are able to care for themselves.

In 2023, about 195 IHN-CCO members with an SPMI (with no co-occurring SUD diagnosis) were enrolled or supported at some point throughout the year in IHN-CCO care coordination (about 3.8 percent of IHN-CCO adult members with SPMI). Members with Schizophrenia and other psychological conditions had the highest care coordination enrollment. When reviewing enrollment by REALD and Gender Identity, IHN-CCO members who identify as Black or African American had the lowest care coordination enrollment rate (1.4%), followed by members who identify as Hispanic or Latinx. About 85 members with SPMI report speaking a language other than English, about 1.2% of those members were enrolled in care coordination. The members who are not cisgender also had lower enrollment in care coordination when compared to people who report being cisgender.

Sexual orientation data are unavailable. IHN-CCO is in the process of establishing member level survey to support the collection of REALD and gender identity and sexual orientation data on all IHN-CCO members to ensure all project and initiatives are reviewed to address disparities.

D. Brief narrative description

Support IHN-CCO members with SPMI during a mental health crisis.

The following TQS project aims to support IHN-CCO members with SPMI by working to mitigate the impacts of the current mental health service crisis. The target population are IHN-CCO members ages 18 and older with one or more of the following mental health conditions: Schizophrenia or other psychological conditions, Bipolar Disorder, OCD, PTSD, Reoccurring Major Depressive Disorder, and/or Schizotypal personality disorder. Members with known Co-occurring Substance Use Disorder are excluded from the target population.

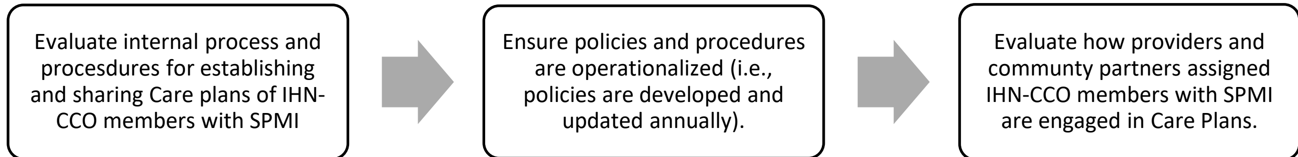
To mitigate the impacts of the current mental health service crisis the project aims to accomplish the following:

- Reduce silos, improve awareness of BH care coordination care plans for target population, reduce the duplication of work, and close gaps in care for the target population by improving multisector engagement in BH care coordination care plans.
- Reduce disparities in enrollment and engagement in BH care coordination for members with SPMI to ensure equity in mental and behavioral health service delivery.
- Engage community organizations who help the target population manage with their SPMI condition while waiting to access essential services.

The first area of focus is *Improving Multisector Engagement in BH Care Coordination Care Plans.* The goal of this focus area is to improve capacity by removing silos, addressing gaps in supporting the implementation of care plans, and reduce the duplication of work between BH care coordination, provider groups, and community-based organizations. The project will establish processes and procedures to share the members' care plan with the organization or facility the members are assigned. The internal workflows for sharing the care plan between IHN-CCO care coordination and provider groups/community organizations will be evaluated by quality and BH care coordination staff using QI tools, such as SWOT analyses or root cause analysis. Once internal workflows are

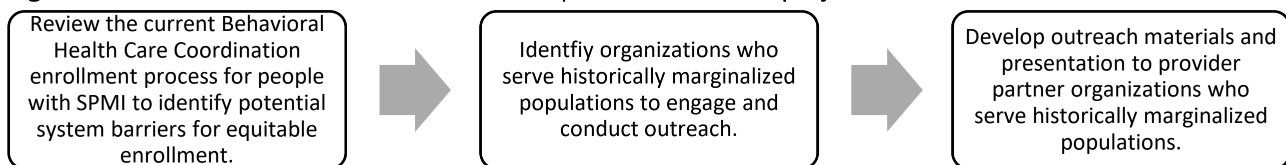
documented and operationalized, the implementation of the care plan between BH care coordination and provider and community partners will be evaluated using a PDSA cycle (see **Figure 1.** for desired outputs for year 1).

Figure 1. Focus Area One: Year one desired outputs for TQS SPMI project.



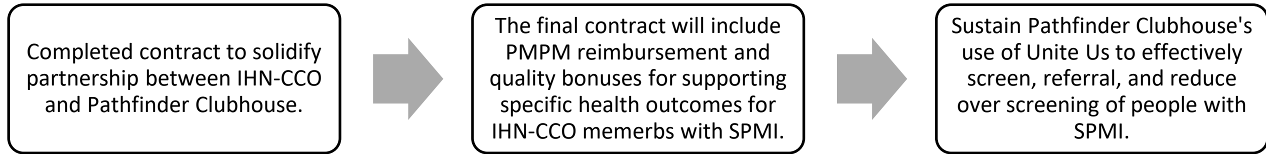
The second area of focus is: *Reduce Disparities in Enrollment and Engagement in BH Care Coordination for members with SPMI.* Given the current disparities in care coordination enrollment (outlined in the project context REALD/SOGI section), there is a need to ensure equitable access. To accomplish this goal of zero disparities in BH care coordination enrollment for members with SPMI by REALD/SOGI, IHN-CCO staff will partner with organizations in the service region who work directly with historically marginalized (i.e., populations of color, LGBTQ+, people with disabilities, etc.) populations to educate and engage on the following: 1). How BH care coordination support people with SPMI; 2) How IHN-CCO members with SPMI qualify for care coordination; 3) How partner organizations can support their populations enrollment in BH care coordination (if they qualify); and 4) Collect feedback on how IHN-CCO Care Coordination department can sustain partnerships with organizations who serve historically marginalized populations to ensure equitable enrollment. IHN-CCO will ask partner agencies for feedback on reducing disparities in enrollment of care coordination for historically marginalized populations. The feedback will support IHN-CCOs internal system analysis for ensuring current procedures are not generating barriers and/or cultivating the disparities in BH care coordination enrollment (see **Figure 2.** for desired outputs for year 1).

Figure 2. Focus Area two: Year one desired outputs for TQS SPMI project.



The third area of focus is: *Engage Community Organizations to Support Members with SPMI.* The third area of focus aims to mitigate the “waiting game” members and care coordinators refer to in the project context section. Pathfinder Clubhouse serves Benton, Lincoln, and Linn counties. They support people with mental illness in finding employment and building skills to sustain employment. Pathfinder also helps people with mental illness engage in their community, reduce isolation, find support through their peers, and have a safe space to find housing, food, and/or transportation needs. BH care coordination staff refer IHN-CCO members with SPMI to resources to support their social determinants of health, but Pathfinder was established to specifically engage those with a mental health condition. Pathfinder Clubhouse has existed in the IHN-CCO service region for a few years and is growing at a much larger rate than anticipated. They were a grant funded project by IHN-CCO. The pilot project showed success in improving health outcomes of IHN-CCO members enrolled in their organization; however, since the pilot project IHN-CCO has not built a sustainability plan with Pathfinder Clubhouse. The TQS project will support the review of how IHN-CCO can sustain the partnership with Pathfinder Clubhouse to ensure they have the resources they need to support their population.

Figure 3. Focus Area three: Year one desired outputs for TQS SPMI project.



E. Activities and monitoring for performance improvement

Activity 1 description: Improve access to essential health care services for people with SPMI by improving the process and procedure for how IHN-CCO's BH Care Coordination team engages the provider teams and community-based organizations on the members' care plan.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Improve the percent of gaps closed for IHN-CCO members with schizophrenia.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
24.7% of care gaps were closed for IHN-CCO members with Schizophrenia.	25.0%	01/2027	25.6%	01/2028
Monitoring measure 1.2	Improve the percent of gaps closed for IHN-CCO members with Major Depressive Disorder/Mood Disorders.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
64.7% of care gaps were closed for IHN-CCO member with Major Depressive Disorder/Mood Disorders.	65.0% of care gaps are closed for IHN-CCO member with Major Depressive Disorder/Mood Disorders.	01/2027	65.6% of care gaps are closed for IHN-CCO member with Major Depressive Disorder/Mood Disorders.	01/2028

Activity 2 description: Improve equitable access to care coordination for IHN-CCO members by partnering with IHN-CCO Health Equity Liaison to conduct targeted education for community partners on IHN-CCO BH care coordination.

☒ Short term or ☒ Long term

Monitoring measure 2.1	Partner with organizations who serve historically marginalized populations to educate on IHN-CCO BH care coordination services for people with SPMI.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
BH care coordination is not currently working with or conducting outreach to organizations who serve historically marginalized populations.	A minimum of 2 organizations in the IHN-CCO service region who serve historically marginalized populations will engage in a presentation on IHN-CCO BH care coordination.	07/2025	Presentations on IHN-CCO BH care coordination services are presented to a minimum of 3 organizations annually who serve historically marginalized populations.	01/2027
Monitoring measure 2.2	Reduce disparities in the enrollment of BH care coordination for people with SPMI			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Care coordination enrollment is lower depending on Race and Gender Identity.	Enrollment in BH care coordination for IHN-CCO members with SPMI increases for all members no matter their REALD/GI.	01/2026	Zero disparities are present in BH care coordination enrollment for IHN-CCO enrollment.	01/2027

Activity 3 description: Improve health and social outcomes for IHN-CCO members with SPMI by sustaining and expanding Pathfinder Clubhouse services in the IHN-CCO service region.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Improve access to Unite Us for Pathfinder Clubhouse.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Current Unite Us usage is unknown.	Unite Us use for Pathfinder clubhouse is operationalized	01/2025	Pathfinder Clubhouse has a value-based payment contract for	01/2026

	within their facility to conduct referrals for food, housing, and transportation for their population.		improving screening and referral to food, transportation, and housing services for IHN-CCO members with SPMI.	
Monitoring measure 3.2	Establish a sustainable contract with Pathfinder Clubhouse.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No updated contract with quality-based measures incorporated.	Contract updated with quality-based measures incorporated.	01/2025	Pathfinder meets their quality metrics in their contract.	01/2026

[i] Includes DSNP members between the ages of 18-85 with condition history of hypertension with a recorded HRA as of December 2022.

[ii] Includes DSNP members between the ages of 18-85 with condition history of hypertension with a recorded ICT and ICP as of December 2022.
The cohort includes D-SNP members identified through SHP PHM platform with a history of hypertension.

Section 2: Supporting information (optional)

Not applicable