Request for Applications

Transformation Community Benefit Initiative Reinvestments

Application Deadline: January 31, 2017
Optional Webinar for Q&A: December 1, 2016 at 9 am PDT

Background: Thanks to successful efforts in 2015 to improve quality, Eastern Oregon Coordinated Care Organization (EOCCO) met 13 of the 17 CCO incentive measures enabling the Board of Directors to reinvest $1,000,000 in 2017 in innovative projects to support better health, better health care, and lower costs for EOCCO members and their communities.

The Eastern Oregon Coordinated Care Organization (EOCCO) announces the availability of investments for projects that focus on challenging issues facing EOCCO. This year's program will focus on two areas:

1. Projects that applicants can apply to participate in (Opt-In Projects) to address colorectal cancer screening, adolescent well care visits, clinical and claims data integration and community health workers and
2. Applications to continue successful 2016 EOCCO funded transformation projects.

Program Areas:

I. Opt-In Projects (approximately $700,000 will be invested)

Project	Funding Amount Available Per Grantee	Description
Community Health Worker Learning Collaborative	Up to $3,000 to offset any technology and administrative costs	This learning collaborative will focus on optimizing the use of CHWs in a wide range of settings (clinic, hospital, public health, behavioral health, school) and ensuring sustainability
Adolescent Well Care Visits	Up to $50,000	This project will fund efforts to increase Adolescent Well Care (AWC) visits through well-orchestrated community events, such as weekend AWC clinic events and in-school and community health fairs with onsite AWC visits
Clinical and Claims Data Integration	Up to $30,000	This project is intended to reduce the barriers for clinics to connect to Arcadia and ensure clean and complete data are available for incentive measure reporting.

Colorectal Cancer Screening	Up to $25,000	This project will partner with clinics to conduct a centralized direct mail of FIT tests and mail and telephone reminders.

Additional details on the Opt-In Projects are provided in Appendix 1.

Eligible Organizations for Opt-In Projects : Any interested organization demonstrating the ability to meet the grant requirements.

II. Continuing Current Projects- Grants up to $50,000 (approximately $300,000 will be invested)

Funding is available to organizations proposing to continue successful, currently funded 2016 EOCCO transformation projects. To be funded under this category, applicants must provide sufficient evidence (quantitative and qualitative) that their current project is having the desired impact on their selected incentive measures and community goals.

Eligible Organizations for Continuing Projects: Grantees from the 2016 EOCCO transformation projects.

Application Process to Apply for an Opt-In Project or to Continue a Current Project:

Process: To request EOCCO reinvestment funds, please follow the directions in this RFA. Applications should include the Application Coversheet, a Project Narrative covering all questions described in the RFA for the opportunity selected, a Budget and a Budget Justification. Send your full application in a single PDF to kinga@ohsu.edu **by 5 pm PDT on January 31, 2017**.

Proposals that are not fully described or are otherwise incomplete may be returned to the applicant. A committee appointed by the EOCCO board will make the final funding decisions subject to approval by the EOCCO Board. Applicants should hear about the status of their requests by March 1, 2017. The earliest start date for projects is March 15, 2017 and all projects should end by January 31, 2018.

Questions and Assistance: There will be a webinar for applicants to ask questions about any aspect of the grant program on **December 1, 2016 at 9 am PDT.** To join the teleconference, please use the following phone number and passcode:
Phone Number: 1-866-588-5540
Conference Code: 9267081804

Additionally GOBHI, Moda and OHSU staff members are available to answer questions and to provide feedback on your project design and evaluation plan. Please contact Anne King kinga@ohsu.edu or Sankirtana Danner danners@ohsu.edu and they will provide help or find the best person to provide assistance.

Transformation Community Benefit Initiative Application Coversheet

Name of Applicant Organization: _____

Project Director (person who will be responsible for the overall project):

Name: _____

Title: _____

Organization: _____

Address: _____

Phone Number: _____ Email: _____

Name of Organization to Receive and Manage Funds:

Organization Name: _____

Address: _____

Name of Employee Managing Funds: _____

Phone Number: _____ Email: _____

Funding Opportunity to which the Applicant is Applying (check one):

__ Community Health Worker Learning Collaborative
__ Adolescent Well Care Visit Event
__ Clinical and Claims Data Aggregation
__ Colorectal Cancer Screening
__ Continuing a Current Project

Total Amount Requested (note funding limits): $_____

Project Title: _____

Start Date: ____/____/_____ **End Date:** ____/____/_____

Project Purpose (do not exceed space below):

Signatures:

I hereby certify that this proposal is fully approved by our organization for submission to the EOCCO. The statements contained in this application are true and complete to the best of my knowledge and the applicant accepts as a condition of the grant the obligation to comply with all applicable state and federal requirements, policies, standards, and regulations.

Signature of Organization Official: _____

Name: _____ Date: _____

Phone: _____ Email: _____

Application Instructions for Opt-In Projects

If you are applying to participate in an Opt-In project, please submit the Application Cover Sheet, a Project Narrative answering the questions listed below, a Budget and a Budget Justification using the following guidelines and templates. Submit signed Letters of Commitment for any organization that would receive funds from your grant or play a major role in its conduct. A suggested template is included in Appendix 2.

For the Project Narrative, the first set of questions should be answered by all applicants to Opt-In projects. The second sets of questions are specific to each project. Please limit your responses to the entire question set to no more than 5 pages.

Questions for All Opt-In Project Applications

a. Why does your organization want to participate in this project?
b. Who from your organization do you commit to work on this project? What relevant skills do they have?
c. Describe the level of leadership support for this project within your organization. How will your leadership ensure that your organization follows through with the project?
d. What could cause your organization to have trouble with the project and how could you reduce this risk(s)?
e. Will your organization sustain this effort once the project ends? If so, how?
f. Please list the members of the project team, their organization, their roles and responsibilities on the project and their email addresses so that they can be invited to project meetings.
g. Please list the organizations involved in your project and fill out a Letter of Commitment form for each collaborating organization.

Questions Specific to Particular Opt-In Projects

A. Community Health Worker Learning Collaborative

a. Please indicate your organization's willingness to start billing the EOCCO for Medicaid CHW services within 6 months of the start of the project.

B. Adolescent Well Care Event

a. Describe your proposed event (see requirements in Appendix 1). Include a plan for developing and staffing the event, using data and outreach to identify and communicate with adolescents needing AWC visits and their parents and utilizing incentives and other strategies to encourage AWC completion.

b. List the Incentive Measures (in addition to AWC) that you plan to target at the event and describe how you will provide services that will improve the Incentive Measures.
c. Describe how any clinical services will be provided during your event and who will provide them.
d. Describe a plan for billing EOCCO for the AWC visit and any additional services provided, particularly those that include Incentive Measure activities such as SBIRT, depression screening and effective contraception use.

C. Clinical and Claims Data Integration

a. Describe how you propose to implement this project in your clinic, including plans to work with Arcadia on the initial connection, conduct data cleaning, implement workflows for measures not currently being tracked and telephone patients to obtain missing data.
b. Describe how you will validate your data once the connection to Arcadia is made to ensure that it is "clean."
c. Describe plans to maintain your connection to Arcadia and maintain validated data once the grant funds are expended.

D. Colorectal Cancer Screening

a. Describe how your organization will ensure the success of the project, including: providing adequate staff time and supervision to ensure that the mailing vendor has what it needs to mail FIT tests and conduct follow up, ensuring that returned FIT tests are transported to the laboratory and patients receive results and follow up if needed.
b. Describe how you will partner with an LCAC, PFAC or other community partner to assist with developing and/or distributing culturally appropriate patient education materials to encourage patients to return their completed FIT tests.

Application Instructions for Continuing Current Projects

If you are applying for funds to continue a 2016 project, please submit an Application Cover Sheet, a Project Narrative answering the questions listed below, a Budget and a Budget Justification using the following guidelines and templates. Submit signed Letters of Commitment for any organization that would receive funds from your grant or play a major role in its conduct. A suggested template is included in Appendix 2.

Project Narrative **(up to 5 pages)**

Please follow the instructions below to complete your project narrative, providing complete answers to each question.

A. What are the goals of this project?

B. What incentive measure(s) will your project directly address? (See Appendix 3 for the 2016 CCO Incentive Measures and Appendix 4 for the latest report on Incentive Measure Performance by County.)

C. Describe the outcomes and data from your 2016 project that supports continuing this effort in 2017.

D. What activities will you undertake to address the targeted incentive measure or goal?
(Please describe the major steps or events in your project and the month when you expect each step will happen. Be detailed enough so that someone not familiar to the project can understand what will happen.)

E. What changes do you plan to make to your project compared to 2016 and what has led you to these changes?

F. Well selected metrics help us measure the outcomes of our work. Please choose two or three metrics that will enable you to know if your project has been successful and complete the following table.

Targeted Metric	Activity Planned	Metrics*	Goal (definition of success)
EXAMPLE: Dental sealants	Wellness fair with onsite dental sealant services	Number of kids who received sealants at last year's wellness fair (baseline)	75 kids will receive sealants which will be a 20% increase over last year
		number of kids who receive sealants this year (change)	
EXAMPLE: Developmental screening	Phone call reminders on behalf of community clinics to families of kids needing screenings	Number of developmental screens last year at participating clinics (baseline)	15% increase in completed screens over prior year
	Raffle at each clinic for families obtaining screening	Number of completed screens this year at participating clinics (change)	
1.			
2.			
3.			

*If funded, updates to the EOCCO Board on the status of your project and its metrics will be due with your evaluation report at the end of the following months: May 2017, October 2017 and February 2018.

G. What could cause this project to have trouble or fail and how could you reduce this risk(s)?

H. Will your organization be able to sustain this effort once the project ends? If so, how?

I. Please list the members of the project team, their organizations, their roles and responsibilities on the project and their email addresses so that they can be invited to technical assistance meetings.

J. Please list the organizations involved in your project and fill out a Letter of Commitment form for each collaborating organization.

BUDGET TEMPLATE

Please use the template below for your budget. Funded activities may include, but are not limited to: personnel, travel expenses, meetings and supplies and consultants. Indirect costs are capped at 10%. Non-project related indirect expenses, funds for capital expenditures (e.g. major non-technology equipment, building renovations) and costs related to enhancing reimbursements or supporting state-covered services cannot be funded through these grants. For Opt-In Projects you may not request more funding than the amount offered. For Continuing Current Projects you may request up to $50,000.

Start date of project: _____ ***End date of project:*** _____

Budget							
Personnel:						**In-Kind Cash Contribution**	**In-Kind non-Cash Contribution**
Name	**Role**	**FTE**	**Salary Requested**	**Benefits Requested**	**Total Requested**		
Equipment and Supplies:							
Name of Item	**Description**				**Total Requested**		
Travel:							
Location	**Description**				**Total Requested**		
Other Expenses:							
Name of Item	**Description**				**Total Requested**		
GRAND TOTAL					**$**		

Budget Justification

Please provide a narrative budget justification detailing the costs included in your budget. If in-kind contributions are budgeted, please provide a list of the source of each contribution, the name of the organization providing it and whether the donation is in cash or non-cash (e.g. labor, etc.)

Appendix 1: Opt-In Projects

Community Health Worker Learning Collaborative

Purpose

Coordinated Care Organizations have shown increasing support for Community Health Workers in recent years, with particular attention paid to their valuable role in connecting with difficult to reach populations and those requiring extra support in accessing health care. As of October 2015, the Oregon Health Authority has certified over 700 CHWs and those in similar roles (e.g. peer support specialists and health navigators).[2,3] CHWs can play a critical role in addressing social determinants of health, linking patients to resources, and helping patients navigate the health system. The EOCCO has been a leader in this support by providing distance-learning CHW training and establishing reimbursement for CHW services when provided by a certified worker.

Despite its support for CHW staffing the EOCCO has received few claims related to CHW delivered services. Numerous EOCCO grants have included the use and training of CHWs as part of their programs; so it is clear that there is a gap between the intentions to utilize the CHW role and the outcomes with regard to billing services. This project will focus on optimizing the use of CHWs in a wide range of settings (clinic, hospital, public health, behavioral health, school) and ensuring sustainability.

Project Plan

This project will consist of a 6-8 session learning collaborative that will meet every other week for about 4 months. Participants will be clinicians, CHW supervisors, and leadership from clinics, hospitals, behavioral health providers, public health, schools and other providers that wish to optimize their use of existing CHWs. The learning collaborative will be conducted in the ECHO format. ECHO is a tele-mentoring program that has been shown to be an effective educational model. The ECHO sessions will last one to 1.5 hours and begin with a 15-20 minute didactic presentation followed by case-based learning where experts present cases and the group discusses them.

Learning Collaborative Topics include:

- ***Utilizing CHWs***- Potential roles and responsibilities of CHWs and benefits of integrating them into various settings, how to engage CHWs to solve clinical challenges, and how to ensure CHWs can work at the "top of their license."

- ***Team-based Care***- Optimizing the clinician-CHW relationship to deliver optimal care.

- ***Workflow analysis***- Understanding how to analyze organizational workflows to effectively integrate CHWs into the organization.

- ***Sustainability-*** How some organizations are successfully sustaining CHWs and how to establish billing.

Participants

Applicants are encouraged to propose a team to participate in the Learning Collaborative. The team should include those in a position to champion change in their organizations, such as clinicians, CHW supervisors, or managers.

Applicant Requirements

Participating organizations must agree to begin billing the EOCCO for CHW services within 6 months of the start of the project.

Metrics

This proposal has the potential to impact the following metrics:

- ED Visits
- Follow-up after hospitalization for mental illness
- Adolescent well care visits
- Colorectal cancer screening
- Timeliness of prenatal care

Timeline

	Q1	Q2	Q3	Q4
Pre-Learning Collaborative Data Collection (survey of needs, readiness, workflow description)				
Learning Collaborative				
Post-Learning Collaborative Data Collection (survey of satisfaction, readiness)				

Budget

Participating organizations may request up to $3,000 to offset technology costs (web cameras, speakers, etc.) and setup administrative expense.

Appendix 1: Opt-In Projects

Adolescent Well Care Visits Event

Purpose

The American Academy of Pediatrics Bright Futures recommends that all children aged 11-21 receive annual well care (AWC) visits, a standard with which Oregon CCO policies align. Annual well care visits provide a key opportunity to screen for potential health conditions and support continued health education and development. Despite these recommendations and CCO support, Oregon's Medicaid population lags in receipt of AWC visits compared to other states that track this measure. Of particular importance to this current proposal, during the 2015 reporting year, EOCCO did not meet this measure, with a final rate of 25.5%.

The Oregon Health Authority has identified a number of barriers to meeting the AWC target, including the need for a cultural shift that prioritizes AWC visits, missed opportunities to conduct AWC visits, and ensuring that clinic workflows and school-based health centers are optimized and coordinated to ensure these visits take place. Prior EOCCO grant projects have addressed this measure through health fairs, coordination with school-based health centers, and use of community health workers for patient education and outreach. A major shift in the last grant period included strong efforts by grantees to conduct AWC visits during well-orchestrated events, such as weekend AWC clinic events and in-school and community health fairs with onsite AWC visits. Successful projects incorporated targeted outreach to adolescents and their families, convenience and incentives. This proposal will allow local groups to develop or continue a plan for increasing AWC visits.

Project Plan

Applicants should propose a project to hold an event designed to help boost the community's AWC visits in a short time frame. Examples of such projects include:

- AWCs during a community health fair
- School-based AWC fair
- Clinic-based weekend or weeknight AWC event

Applicants should describe a plan to develop and staff the event, using data and outreach to identify and communicate with adolescents needing AWC visits and their parents and utilizing incentives and other strategies to encourage AWC completion. Projects may include innovative staffing strategies such as multi-clinic collaborative events or hiring locum tenens physicians or other clinicians during a discrete period of time during which AWC visits will take place (e.g. a weekend AWC "event.")

Applicants or their partners should provide a plan for billing for the AWC visit and any additional services provided, particularly those that include incentive measure activities such as SBIRT, depression screening and effective contraceptive use. Priority will be given to plans that include multiple measures.

Participants

Applicants and collaborators may include, but are not limited to: clinics, hospitals, health departments, school-based health centers, local community advisory councils, and youth advisory councils.

Applicant Requirements

Participating organizations must agree to bill the EOCCO for services provided during the event. The EOCCO Incentive Measure Billing Reference Guide is provided in Appendix 5.

Applicants will be required to report key metrics, such as: overall attendance at the event, participant satisfaction with the event, number of services provided to EOCCO and non-EOCCO community members.

Metrics

While the AWC visit measure is the primary target for this proposal, other measures may also see improvement as a result of this effort.

- Adolescent well care visits
- SBIRT
- Depression screening and follow-up plan
- Effective Contraceptive Use

Timeline

	Q1	Q2	Q3	Q4
Finalize staffing, project plan and measurement plan for the event				
Event planning				
Data collection and educational outreach planning				
Educational outreach				
AWC visit completion event (August through October is suggested)				
Measure outcomes				

Budget

Up to $50,000 may be requested per event to pay for contracted clinic staff, general staffing, event planning, materials and incentives. Cost effectiveness of events will be considered in funding decisions.

Appendix 1: Opt-In Projects

Clinical and Claims Data Integration

Purpose

EOCCO has engaged Arcadia to implement an analytics platform that integrates clinical and claims data and provides tools to help clinics manage quality and improve population health. Arcadia Analytics will be provided to primary care practices allowing practices to view practice performance, understand cost and utilization, and manage patient outreach across the integrated data set. For example, practices should be able to identify patients with quality measure and clinical care gaps in real time.

The contract with Arcadia provides for assistance with backend connection to EHR data, data aggregation, data validation and training. The Arcadia Data Analytics Platform provides a data dashboard of up to 200+ quality measures, cost and utilization analyses, and patient risk and management tools.

The implementation of Arcadia across EOCCO will greatly facilitate incentive measure data reporting to the state for clinical measures and should help EOCCO achieve metrics related to claims data. However, as many currently funded EOCCO grantees who are engaging in data cleaning have discovered, clinical datasets, particularly for measures not previously reported, often contain errors and missing data. This project would provide support for clinics to implement work flows for measures not currently being tracked within the EHR, to conduct outreach to obtain missing data and to clean data for all clinical incentive measures listed below including the new tobacco prevalence measure.

Project Plan

This project would provide support for clinics that agree to connect to Arcadia within the first 5 months of 2017. Funds would be made available for clinics to hire temporary staff or increase hours of current staff to work with Arcadia staff on the initial connection, conduct data cleaning, implement workflows for measures not currently being tracked, telephone patients to obtain missing data and otherwise validate clinical data connected to Arcadia.

Participants

Eligible participants include EOCCO-contracted primary care clinics with 400 or more EOCCO members. Both practices already working with Arcadia and practices not yet working with Arcadia are eligible to apply.

Applicant Requirements

Grantees are expected as part of the project to clean and complete their data for the incentive metrics listed under "Metrics" below.

Metrics

- Colorectal cancer screening
- Tobacco prevalence
- Timeliness of prenatal care
- Diabetes HbA1c poor control
- Hypertension Control
- Depression screening and follow up plan

Timeline

	Q1	Q2	Q3	Q4
Arcadia connection and integration (4 month target to connect and be approved to receive second set of funding)				
Data cleaning				
Quality check of data				

Budget

Up to $30,000 per clinic. Payment will be made in increments (example: for a $30,000 grant, payments may consist of $3,000 for up-front costs, $15,000 once connection is made for staffing and a $12,000 bonus for completion and quality check.) Matching contributions will be considered in funding decisions.

Appendix 1: Opt-In Projects

Colorectal Cancer Screening

Purpose

According to the 2015 Oregon Health Authority report on the state of colorectal cancer (CRC) screening, approximately 36% of Oregonians in the recommended age range are not obtaining screening as recommended, despite the fact that routine screening can result in early cancer diagnosis and reduce the chance of death. The gap in cancer screening of all types, including for CRC, is wider in rural and low income areas. Furthermore, for the 2015 reporting year, the EOCCO did not meet the benchmark for CRC screenings, with a final rate of 36%.

The purpose of this proposed project is to increase CRC screening rates among EOCCO members to ensure targets are met by implementing a centralized FIT mailing program and patient-centered educational outreach to reduce barriers to screening. Previous EOCCO grant funded projects addressing the CRC measure have included efforts such as distributing FOBT kits at health fairs, mailing FITs from a clinic, and clinic staff calling patients in need of screening. While many of these efforts have shown positive outcomes, there have been challenges, including low returns of completed tests to the clinic, extensive time involved for clinic staff to manage outreach, and concerns about sustainability. This proposal focuses on FIT, as it has been shown to be a preferred (and sensitive) method of screening in low income communities. A centralized direct mail program that includes patient outreach and mail and telephone reminders will aim to address the aforementioned barriers, including low return rates and clinic staff burden. An additional patient educational outreach component will serve to address misconceptions and lack of knowledge about CRC screening and FITs, in particular.

Project Plan

Centralized FIT Mailing and Follow up Calls: This project will implement the use of a centralized vendor to mail FITs to patients who are due for CRC screening according to US Preventive Task Force recommendations. EOCCO representatives will produce a list of patients eligible for screening by clinic, and work with clinics to finalize this listing. EOCCO representatives and clinics will work with the vendor to ensure that the outreach materials are clinic-centered (e.g. use of mailings with clinic letterhead and physician signatures). A designated representative from EOCCO and each clinic will be responsible for interfacing with the vendor. FIT tests would be returned to the patient's clinic for routing to the laboratory of the clinic's choice. This would ensure that the test results make it back to the patient's PCP. The testing would be completed. Follow up calls would be provided by the vendor centrally, but callers would let patients know that they are calling on behalf of their doctor's office.

Educational Outreach:

Patient Education*:* To address the barriers around patient willingness to complete CRC screening, this project will also include coordination with local community advisory councils (LCAC), patient and family advisory councils (PFAC), or other community partners, to support the creation of patient-centered and culturally appropriate educational materials to increase awareness of the FIT option and willingness to complete the test. Additionally, this educational outreach component will address awareness and willingness of the need for follow up colonoscopy after abnormal FITs. The method of outreach will be proposed by the applicant, but could include posters, flyers, newspaper articles, advertisements, social media, or other means.

Clinic Education: This project will include education to participating clinics about the benefits of FIT mailings. Clinics will be invited to a webinar conducted by OHSU staff.

Participants

Participants of this project will include:

- An EOCCO representative: This individual will be responsible for generating clinic-level lists of eligible patients based on claims data and serve as the liaison between participating clinics and the selected vender.
- Primary care or internal medicine clinic point of contact: This individual and their implementation teams will be responsible for working with the EOCCO representative to review the list of eligible patients. The point of contact will also provide logos/letterhead to ensure that direct-mail materials are clinic centered. They will also develop a process to coordinate follow ups colonoscopy for abnormal FIT screening results
- LCAC, PFAC, or other community partner(s): Will work with the clinic partner on creating and/or distributing culturally appropriate patient education materials to promote completion of screening FITs and potential follow up colonoscopy
- FIT Mailing Vendor (contracted by EOCCO): Mail FITs to eligible patients and complete reminder mailings and centralized calls on behalf of the provider.

Applicant Requirements

Applicants must describe adequate staffing to participate in the project as described. Applicants are required to partner with an LCAC, PFAC or other community partner to assist with developing and/or distributing culturally appropriate patient education materials to encourage patients to return their completed FIT tests.

Metrics

- Colorectal cancer screening

Timeline

	Q1	Q2	Q3	Q4
Data Extraction				
Engage with community partners				
Creation of patient education materials				
Patient education outreach				
FIT Mailings				
Measure outcomes				

Budget

Up to $25,000 per grantee.

Appendix 2
Letter Template

Agreement to Participate in EOCCO Project

Dear ***Name of project director*****,**

We look forward to participating in the ***Project Name*** starting ***date*** and ending ***date.***

Our organization agrees to ***describe what the collaborating organization is expected to do including any staff responsibilities.***
We understand that we will receive ***list any funds being provided to the collaborating organization.***

Thank you for including us in this important project.

Sincerely,

Signature
Name spelled out
Organization name
Email address
Phone number

Appendix 3
2016 CCO Incentive Measures

To learn how EOCCO and OHA track the metrics, please contact eoccometrics@modahealth.com or visit the Oregon Health Authority website page: Technical Specifications and Guidance Documents for CCO Incentive Measures. Please note that all
metric performances are measured on an annual basis, using the calendar year.

Measure Definitions	Data Source
Alcohol and Drug Misuse Screening *(SBIRT)* Members age 12 and older who received alcohol and drug misuse screening during outpatient visit. Outpatient visits include office visit, home visit, and/or preventive medicine. Full screen or full screen + brief intervention services are required for reimbursement. A brief screen does not count toward this measure.	Medical claims
ED Visits Each visit to an ED that does not result in an inpatient encounter (multiple ED visits on the same date of service is counted as 1 visit)	Medical claims
Developmental screening (0-36 months) Children who turn 1, 2, or 3 years of age in 2016 who had a developmental screening Screening results must be reviewed and interpreted by the provider (physician, NP or PA), discussed with the family, and the patient record must document the screening tool, results and actions taken. Another healthcare provider or early learning and development provider may initiate a developmental screen with a family. As long as the screening tool and full set of answers are shared with the primary care provider who completes the required steps of interpretation, documentation and discussion with the family, the provider (physician, NP or PA) can appropriately bill. While screenings can be completed and scored in advance of provider review and interpretation, results should be reviewed with the family within one month of completion of the screen to be considered valid or current.	Medical claims
Follow-Up after hospitalization for Mental Illness Discharges for members' age 6 years of age and above who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit within 7 days of discharge, and on the date of discharge.	Behavioral health claims
Dental, Mental, Physical Health Assessment for Children in DHS Custody Identified children/adolescents 0 – 17 years of age in DHS custody for 60 days who received a physical health assessment, a mental health assessment, and a dental health assessment within 60 days of the notification date (when CCOs are notified the member is in DHS custody, or within 30 days prior to the notification date.) • Age 1-4 mental health assessment not required • Age < 1 only physical health assessment required • First Tooth or Smiles for Life certified medical providers can conduct and code for a dental assessment (D0191) when performed during a well-child check	Dental, behavioral health, and medical claims

Effective Contraceptive Use Women age 18-50 with evidence of one of the following methods of contraception in 2016: sterilization, IUD, implant, contraception injection, contraceptive pills, patch, ring, or diaphragm. Surveillance of *existing contraception* is included in this measure – which are women utilizing long- acting reversible contraception or permanent contraceptive options who would not otherwise have a pharmacy claim or procedure code in 2016.	Medical and pharmacy claims
CAHPS Access to care • Got care right away for illness/injury/condition as soon as you/child needed • Got an appointment for routine care as soon as you/child needed	State CAHPS survey
CAHPS Satisfaction with Care • EOCCO customer service gave needed information or help • Treated with courtesy and respect by EOCCO customer service staff	State CAHPS survey
Dental Sealants Children ages 6-9 and 10-14 who received a sealant on a permanent molar tooth Dental hygienists can determine need and apply sealants without the direct supervision by a dentist	Dental claims
PCPCH Enrollment Number of members enrolled in PCPCHs by tier	EOCCO Member PCP assignment
Colorectal Cancer Screening Individuals receiving at least one of the following screenings for colorectal cancer either during the measurement year or years prior to the measurement year: • Fecal occult blood test during the measurement year • Colonoscopy during the measurement year or nine years prior to the measurement year • Flexible sigmoidoscopy during the measurement year or four years prior to the measurement year	Medical claims and chart review on sample population, determined by Oregon Health Authority
Timeliness of Prenatal Care Prenatal care provided in the first trimester or within 42 days of enrollment. First trimester is considered first three months of pregnancy, from the first day of the last menstrual period through 13 weeks gestation. <u>Prenatal care</u> Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred, and evidence of one of the following: • Basic physical obstetrical examination (auscultation for fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height • Prenatal care procedure (obstetric panel, echography of a pregnant uterus, documentation of LMP or EDD in conjunction with either prenatal risk assessment and counseling/education, or complete obstetrical history) <u>Postpartum care (one of the following)</u> • Pelvic exam • Evaluation of weight, blood pressure, breasts and abdomen • Notation of postpartum care, including, but not limited to "postpartum care," "PP care," "PP check," or "6-week check" • Preprinted "Postpartum care" form • Pap test	Medical claims and chart review on sample population, determined by Oregon Health Authority

Adolescent Well Care Visits Adolescents age 12-21 with at least one comprehensive well-care visit Well care visit include: • History • Physical exam that includes weight, height, vision, heart, lungs, skin and genitalia • Assessment & plan	Medical claims
Depression Screening and Follow Up Plan Patients age 12+ screened for clinical depression, using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Clinic's Electronic Health Record
Diabetes HbA1c Poor Control Patients age 18-75 with a diagnosis of diabetes, whose most recent HbA1c level (performed during the measurement period) is >9.0%.	Clinic's Electronic Health Record
Hypertension Control Patients age 18-85 with a diagnosis of essential hypertension within the first six months of the year, whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg). Only blood pressure readings performed by a clinician in the provider office are acceptable.	Clinic's Electronic Health Record
Child Immunization Status Combo 2 Children who turned 2 years of age in the measurement year and had all of the following specified vaccinations: Dtap, IPV, MMR, HiB, Hepatitis B, VZV	Public Health Division Immunization Program Registry (ALERT) and MMIS
Cigarette Smoking prevalence Unique members age 13 years or older who had a qualifying visit, who have their smoking and/or tobacco use status recorded as structured data, who are current smokers and/or tobacco users. Each EHR may have different codes to document cigarette smoking and tobacco use. PLEASE INDICATE IF CIGARETTE SMOKING ONLY, AND/OR BROADER TOBACCO USE. Report queries must be able to query the following: 1) Of all your patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded? 2) Of all your patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers? 3) Of all your patients with their cigarette smoking or tobacco use status recorded, how many are smokers and/or tobacco users? For information on tobacco treatment reimbursement, please refer to the EOCCO provider manual http://eocco.com/providers/resources.shtml Qualifying visits include face-to face interaction, office visit, wellness visit, health &behavioral assessment, preventative care services, consultants visit, occupational therapy	Clinic's Electronic Health Records

Appendix 4

2016 Current Incentive Measure Performance by County

2016 EOCCO Incentive Measures Performance Report

Reporting period: incurred January-October 2016 as of October 31, 2016

County	SBIRT	Dental Sealants on Permanent Molars for Children	Effective Contraceptive Use	Timeliness of prenatal care	ED utilization per 1,000 mm	Colorectal cancer screening	Developmental screening in first 36 months of life	Adolescent well care visits	Childhood Immunization
Baker	4.3%	9.4%	28.2%	74.5%	50.9	27.4%	65.5%	22.7%	62.0%
Gilliam	8.5%	14.9%	30.6%	66.7%	38.0	20.0%	17.6%	31.0%	33.3%
Grant	15.3%	16.8%	28.2%	84.6%	62.3	21.8%	40.0%	31.6%	61.5%
Harney	25.6%	7.3%	30.4%	70.0%	42.3	31.7%	76.2%	20.6%	61.5%
Lake	5.5%	14.9%	20.0%	61.9%	40.1	17.6%	27.6%	11.8%	48.1%
Malheur	8.9%	15.6%	26.9%	64.0%	57.3	31.6%	77.8%	27.1%	68.3%
Morrow	27.1%	12.5%	28.0%	68.6%	48.1	30.7%	26.1%	27.8%	70.7%
Sherman	18.0%	7.0%	40.9%	80.0%	42.6	23.0%	40.0%	32.5%	66.7%
Umatilla	15.4%	8.9%	30.1%	63.3%	55.9	30.9%	34.4%	26.5%	64.5%
Union	26.0%	3.9%	33.1%	32.3%	55.0	30.4%	80.4%	26.9%	52.2%
Wallowa	8.5%	5.4%	21.6%	52.6%	24.7	33.3%	67.6%	31.5%	56.0%
Wheeler	35.8%	11.8%	29.4%	83.3%	27.9	32.3%	72.7%	28.6%	60.0%
EOCCO	**15.1%**	**10.3%**	**28.9%**	**61.3%**	**52.9**	**29.5%**	**52.1%**	**26.2%**	**63.0%**
EOCCO 2016 Target	**11.8%**	**17.4%**	**42.7%**	**93.0%**	**51.5**	**39.0%**	**47.7%**	**29.1%**	**75.3%**

Appendix 5

EOCCO Incentive Measure Reference Guide 2016

Metric	Code(s) and Identification	Notes
Adolescent Well-Care Visits	Annual adolescent well-care visit includes history, physical, assessment & plan. **CPT/HCPCS Codes** 99383-99385, 99393-99385, G0438, G0439 **ICD-10-CM Diagnosis** Z00.00, Z00.01, Z00.121, Z00.129, Z00.5	Members ages 12-21 years old receiving at least one comprehensive well care visit during the measurement year.
Assessments Within 60 Days for Children in DHS Custody	**Age 1-3 mental health assessment not required* **Age < 1 only physical health assessment required* If a provider uses (99201-99205), they will qualify for inclusion in the measure as both mental and physical health assessments only if there is a mental health diagnosis on the same claim as the new patient E&M code. This is to reflect assessments that were provided by a psychiatric (nurse or physician) provider. The diagnosis codes that qualify when billed with 99201-99205 for a mental health assessment are: T74.02xA, T74.02xD, T74.12xA, T74.12xD, T74.22xA, T74.32xA, T74.32xD, T74.22xD, T76.02xA, T76.02xD, T76.12xA, T76.12xD, T76.22xA, T76.22xD, T76.32xA, T76.32xD **Physical Health Assessment Codes** 99201-99205, 99212- 99215, 99381-99384, 99391-99394, G0438, G0439 **Mental Health Assessment Codes** 90791-90792, 96101-96102, H0031, H1011, H2000-TG, H0019, H2013, H0037 *H0019: use of this code counts as both mental and physical health assessment for children in PRTS (Psychiatric Residential Treatment Center, POS 56)	Members age 0-17 in DHS custody for 60 days Physical, mental, and dental assessments must be conducted within 60 days of the notification date (when the CCO is notified of the member's placement in DHS) First Tooth or Smiles for Life certified medical providers can conduct and code for a dental assessment (D0191) when performed during a well-child check

<table>
<tr><td></td><td><u>Dental Health Assessment Codes</u>
D0100-D0199</td><td></td></tr>
<tr><td>Childhood Immunization Status 2</td><td>
<table>
<tr><th>Type</th><th>Required</th><th><u>Codes & Diagnoses</u></th></tr>
<tr><td>DTaP</td><td>At least four</td><td>90698, 90700, 90721, 90723</td></tr>
<tr><td>IPV</td><td>At least three</td><td>90698, 90713, 90723</td></tr>
<tr><td>MMR (Measles, Mumps and Rubella)</td><td>At least one or history of measles, mumps, or rubella illness</td><td>90707, 90710, 90708, 90705, 90704, 90706

Measles
B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
Mumps
B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
Rubella
B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9</td></tr>
<tr><td>HiB</td><td>At least three</td><td>90645-90648, 90698, 90721, 90748</td></tr>
<tr><td>Hepatitis B</td><td>At least three or history of hepatitis illness</td><td>90723, 90740, 90744, 90747, 90748, G0010

B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51</td></tr>
<tr><td>VZV</td><td>At least one or history of varicella zoster (e.g., chicken pox) illness</td><td>90710, 90716
B01.1, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0,
B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31,
B02.22, B02.33, B02.34, B02.49, B02.7, B02.8, B02.9</td></tr>
</table>
</td><td>Members who turn 2 years of age during 2016

Date of service must be on or before the child’s second birthday

DTaP, IPV, & Hib administered prior to 42 days after birth cannot be counted

Note: EOCCO relies on the Public Health Division Program Registry (ALERT) data</td></tr>
<tr><td>Cigarette smoking prevalence</td><td>DOCUMENTATION: Each EHR may have different codes to document cigarette smoking and tobacco use.</td><td>Members age 13+ who had a qualifying visit where</td></tr>
</table>

	PLEASE INDICATE IF CIGARETTE SMOKING ONLY, AND/OR BROADER TOBACCO USE. 1) Of all patients with a qualifying visit, how many have their cigarette smoking or tobacco use status recorded? 2) Of all patients with their cigarette smoking or tobacco use status recorded, how many are cigarette smokers? 3) Of all patients with their cigarette smoking or tobacco use status recorded, how many are smokers *and/or* tobacco users? For information on tobacco treatment reimbursement please refer to the EOCCO provider manual http://eocco.com/providers/resources.shtml	their smoking and/or tobacco use status is recorded as structured data, who are current smokers and or tobacco users. ***Electronic health record measure*
Colorectal cancer screening	**Colonoscopy CPT Codes** 44388-44394, 44397, 45355, 45378-45387, 45391, 45392 **Colonoscopy HCPCS Codes** G0105, G0121 **DX Codes** 45.22, 45.23, 45.25, 45.42, 45.43 **Fecal Occult Blood Test CPT Codes** 82270, 82274 **Fecal Occult Blood Test HCPCS Codes** G0328 **LOINC Codes** 2335-8, 12503-9, 12504-7, 14563-1, 14564-9, 14565-6, 27396-1, 27401-9, 27925-7, 27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2 **Flexible Sigmoidoscopy CPT** 45330-45335, 45337-45342, 45345 **Flexible Sigmoidoscopy HCPCS** G0104 **DX code** 45.24	Members age 51-75 ***Exclusions:*** **Colorectal Cancer HCPCS** G0213-G0215, G0231 **Colorectal Cancer ICD-10** C18.0-C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048 **Colectomy CPT** 44150-44153, 44155-44158, 44210-44212 **Colectomy ICD-10** 0DTE0ZZ, 0DTE4ZZ, 0DTE8ZZ

Controlling Hypertension (High Blood Pressure)	Patients whose blood pressure at the most recent visit is adequately controlled • Systolic blood pressure <140 mmHg • Diastolic blood pressure <90 mmHg ***Outpatient Services:*** *Office Visit, Face-to-Face Interaction, Preventive Care Services, Home Health Services, Annual Wellness Visit* ***Exclusions:*** *Evidence of ESRD (End Stage Renal Disease), Chronic Kidney Disease Stage 5, Dialysis or renal transplant, Diagnosis of pregnancy*	Members 18-85 years of age who had a diagnosis of essential hypertension within the first six months of 2016 or any time prior to 2016 and who received a qualifying outpatient service in 2016. ***Electronic health record measure*
Dental Sealants on Permanent Molars for Children	**Dental Sealant HCPCS Code** D1351 ***Dental hygienists can determine the need for and apply sealants without the supervision of a dentist.*	Members age 6-14
Depression screening and follow up plan	Patients screened for depression on the date of the encounter, using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen. The following Grouping Value Sets are used to identify follow-up planning: • Referral for Depression Adolescent SNOMED-CT Value Set (2.16.840.1.113883.3.600.537) • Referral for Depression Adult SNOMED-CT Value Set (2.16.840.1.113883.3.600.538) • Additional evaluation for depression- adolescent SNOMED-CT Value set (2.16.840.1.113883.3.600.1542) • Additional evaluation for depression- adult SNOMED-CT Value set (2.16.840.1.113883.3.600.1545) • Follow-up for depression- adolescent SNOMED-CT Value Set (2.16.840.1.113883.3.600.467) • Follow-up for depression- adult SNOMED-CT Value Set (2.16.840.1.113883.3.600.468) • Depression medications – adolescent RxNorm Value Set (2.16.840.1.113883.3.600.469) • Depression medications – adult RxNorm Value Set (2.16.840.1.113883.3.600.470) • Suicide Risk Assessment SNOMED-CT Value Set (2.16.840.1.113883.3.600.559)	Members age 12+ with at least one eligible encounter in 2016 ***Exclusions:*** 1. Patients with an active diagnosis for depression or bipolar disorder. (Identified by Grouping Value set codes) 2. Patients refusing to participate (SNOMED-CT Value Set) or an urgent/emergent situation where time is the essence and delaying treatment would jeopardize patient

<table>
<tr><td></td><td>Note: the follow up plan must be related to a positive depression screening, example: “Patient referred for psychiatric evaluation due to positive depression screening.”

Also note that the use of PHQ9 is allowable as follow up to a positive PHQ2</td><td>health (Medical or Other reason not done Value Set) are considered excluded from the denominator.

**Electronic health record measure</td></tr>
<tr><td>Developmental screening in the first 36 months of life</td><td><u>Developmental Screening CPT Code</u>
96110</td><td>Members who turn 1, 2, or 3 years of age in 2016</td></tr>
<tr><td>Diabetes: HbA1c Poor Control</td><td>Patients whose most recent HbA1c level (performed during 2016) is >9.0%, if the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during 2016.

<u>HbA1c Test CPT Codes</u>
83036, 83037, 3044F, 3045F, 3046F

<u>LDL-C Test CPT Codes</u>
3048F, 3049F, 3050F, 80061, 83700, 83701, 83704, 83721

Outpatient Services:
Office Visit, Face-to-Face Interaction, Preventive Care Services – Established Office Visit, 18 and Up, Preventive Care Services – Initial Office Visit, 18 and Up</td><td>Members 18-75 years of age who had a diagnosis of diabetes during or any time prior to 2016 and who received a qualifying outpatient service during 2016

**Electronic health record measure</td></tr>
<tr><td>Effective contraceptive use among women at risk of unintended pregnancy (ECU)</td><td>*Please code for surveillance of existing methods for women utilizing long-acting reversible or permanent contraception. See Table 2 for surveillance codes.

<table>
<tr><th><u>Description</u></th><th><u>ICD-10</u></th><th><u>CPT</u></th><th><u>HCPCS</u></th></tr>
<tr><td>Female Sterilization</td><td>Z30.2</td><td>58565, 58600, 58605, 58615, 58611, 58670, 58671, 58340, 74740</td><td>A4264, 58340, 74740</td></tr>
<tr><td>Intrauterine device (IUD/IUS)</td><td>Z30.430, Z30.433, Z30.431, Z97.5, 0UH97HZ, T83.31xA, T83.59xA</td><td>58300</td><td>J7300, J7302, vS4989, Q0090, S4981</td></tr>
</table>
</td><td>Women age 15-50 at risk for unintended Pregnancy

Include NDC Code NDC Code list

Postpartum contraception counts

Women who are pregnant during the year who did not receive</td></tr>
</table>

	Hormonal implant	Z30.019, Z30.49, T83.498A	11981, 11983	J7306, J7307, S0180
	Injectable (1-month/3-month)	Z30.013, Z30.42		J1050, J1051, J1055, J1056
	Oral contraceptive	Z30.011, Z30.41		S4993
	Patch	Z30.9, Z30.40		J7303
	Vaginal ring	Z30.9, Z30.40		J7303
	Diaphragm	Z30.013	57170	A4266

Table 2 - **Effective Contraception Surveillance Codes* Women using long-acting reversible contraception or permanent contraceptive options, who would not otherwise have a pharmacy claim or procedure code during 2016

Z30.41	Encounter for Surveillance of contraceptive pills
Z30.431	Encounter for routine checking of IUD
Z30.42	Encounter for surveillance of injectable contraceptive
Z30.49	Encounter for surveillance of other contraceptives
Z30.018	Encounter for initial prescription of other contraceptives
Z30.019	Encounter for initial prescription contraceptives, unspecified
Z30.40	Encounter for surveillance of contraceptives, unspecified
Z30.8	Encounter for other contraceptive management
Z30.9	Encounter for contraceptive management, unspecified
Z97.5	Presence of intrauterine contraceptive device

Pregnancy Exclusions:
Pregnancy Diagnosis: Z34.00, Z34.80, Z34.90, Z33.1, Z32.01, Z64.0 **Pregnancy CPT Codes:** 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 59425, 59426

postpartum contraceptive are excluded

Exclusions (ICD-10s):

Hysterectomy Diagnosis
Z90.710
Bilateral Oophorectomy Procedures
0UT20ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT00ZZ, 0UT08ZZ, 0UT0FZZ, 0UT10ZZ, 0UT17ZZ, 0UT18ZZ, 0UT1FZZ, 0UT24ZZ, 0UT04ZZ, 0UT14ZZ
Natural Menopause Diagnosis
N92.4, N95.0, N95.1, N95.2, N95.8, N95.9, Z78.0
Premature Menopause Diagnosis
E89.40, E89.41, E28.310, E28.319
Congenital Anomalies of Female Genital Organs Diagnosis
Q50.02, Q51.0

Follow-up after hospitalization for mental illness	**Stand Alone Visit CPT Codes** 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510, 90846, 90791, 90792, 90832-90834, 90836-90838 **Stand Alone Visit HCPCS Codes** G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0006, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, H2021, M0064, S0201, S9480, S9484, S9485, T1015, T1016	Discharges from acute inpatient settings (including acute care psychiatric facilities) for members' age 6 years of age and above who were hospitalized for treatment of selected mental health disorders.

	<u>Follow-Up After Hospitalization (FUH) Visit Codes (Group 1)</u> 90839, 90840, 90845, 90847, 90849, 90853, 90867-90870, 90875, 90876 ***WITH POS:** 03,05,07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 **<u>Follow-Up After Hospitalization (FUH) Visit Codes (Group 2)</u>** 99221-99223, 99231-99233, 99238, 99239, 99251-99255 ***WITH POS:** 52,53 **Transitional care management services where the date of service on the claim is 29 days after the mental illness discharge date:** CPT 99496 **<u>Follow-Up After Hospitalization (FUH) UB Revenue Codes (Group 1)</u>** *There is no need to determine the practitioner type for follow-up visits identified by the following UB revenue codes:* 0513, 0900-0905, 0907, 0911-0917, 0919 **<u>Follow-Up After Hospitalization (FUH) UB Revenue Codes (Group 2)</u>** *A visit to a non-behavioral health facility in conjunction with a principal diagnosis code from an ICD-9 code in the [Mental Illness Value Set].* 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983	Includes follow-up services provided on the date of discharge
Prenatal and postpartum care: Timeliness of Prenatal Care	**<u>Prenatal care *(one of the following)*</u>** *Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred* • Basic physical obstetrical examination (auscultation for fetal heart tone, pelvic exam with obstetric observations, or measurement of fundus height • Prenatal care procedure (obstetric panel, echography of a pregnant uterus, documentation of LMP or EDD in conjunction with either prenatal risk assessment and counseling/education, or complete obstetrical history) **<u>Postpartum care *(one of the following)*</u>** • Pelvic exam • Evaluation of weight, blood pressure, breasts and abdomen	A prenatal visit in the first trimester or within 42 days of enrollment A postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery Includes visits with PAs, NPs, midwives and RNs, provided a co-signature by

	• Notation of postpartum care, including, but not limited to "postpartum care," "PP care," "PP check," or "6-week check" • Preprinted "Postpartum care" form • Pap test	a physician is present, if required by state law
SBIRT Screening, Brief Intervention & Referral to Treatment	Please provide full screen **or** full screen +brief intervention services for reimbursement. A brief screen does not count toward this measure. **Full screen** CPT code 99420, with diagnosis code *Z13.89 **or** Z13.9 This coding combination is also used when a brief intervention lasting less than 15 minutes is performed. **Z13.89 may be used as standalone codes, i.e., they do not need to be paired with CPT 99420 for inclusion in the numerator* **Full Screen and Brief Intervention** *CPT Code 99408* 15-29 minutes administering and interpreting a validated alcohol or drug-screening tool, plus performing face to face brief intervention *CPT Code 99409* 30+ minutes administering and interpreting a validated alcohol or drug-screening tool, plus performing face to face brief intervention	Members age 12+ who had an outpatient visit (office visit, home visit, and/or preventative medicine) CPT codes should be appended to E/M service, with modifier 25. Documentation should support both services.

EOCCO Referral and Authorization Guidelines, Moda Health Clinical Editing Policy Information, DMAP Prioritized List of Health Services and DMAP Provider Guidelines outline in the current Oregon Administrative rules apply. Services are subject to eligibility and plan provisions in effect at the time services are rendered.

Please visit EOCCO.com to learn more about Billing and Payments. If you have comments, questions, or would like additional information on codes and billing, please contact EOCCOmetrics@modahealth.com.