Request for Applications

Transformation Community Benefit Initiative Reinvestments

A. Application Deadline: January 31, 2018

B. Background:

Thanks to successful efforts in 2016 to improve quality, Eastern Oregon Coordinated Care Organization (EOCCO) met 13 of the 17 CCO incentive measures. This is enabling the Board of Directors to reinvest approximately $1,000,000 in 2018 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. Opt-In Projects to address adolescent well care visits, childhood immunizations and developmental screenings, cigarette smoking prevalence, colorectal cancer screening, reducing emergency department visits, and population health management for hypertension and diabetes.

2. Applications to continue successful 2016 or 2017 EOCCO funded projects that focus on one or more incentive measures the county is having trouble meeting and that do not overlap with the above Opt-In opportunities.

C. Program Areas:

1. <u>Opt-In Projects</u>

Project	Funding Amount Available Per Grantee	Description
Adolescent Well Care Visits	Up to $40,000	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.
Childhood Immunizations and Developmental Screenings	Up to $25,000 for immunization only projects; Up to $35,000 for immunization plus	Interventions to increase immunization rates and timeliness of vaccinations for children under two years of age and to increase developmental screening rates for children three and under.

	developmental screening projects	
Cigarette Smoking Prevalence	Up to $25,000	Reduce prevalence of tobacco use, ensure prevalence data is being captured in electronic health records and encourage use of EOCCO cessation benefits for individuals ages 13 and up through evidence-based interventions.
Colorectal Cancer Screening	Up to $25,000	Participate in a FIT direct mail campaign run by EOCCO. Clinic responsibilities include scrubbing lists, lab coordination, customizing mailing materials and working closely with EOCCO project staff and with the FIT direct mail vendor.
Emergency Department Utilization	Up to $50,000	Interventions to reduce ED utilization for physical health visits based on baseline county-level 2016 data.
Population Health Management for Hypertension and Diabetes	Up to $30,000	Implement a population health management project focused on hypertension and diabetes. Project should include using Arcadia Analytics or an alternative method to build and prepare registries for daily use for population health management and identifying 1-2 quality improvement activities.

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

Eligible Organizations for Opt-In Projects: See Appendix 1 for organizations eligible to apply for Opt-In projects.

2. <u>Continuing Current Projects- Grants up to $50,000</u>

Funding is available to organizations proposing to continue successful, previously funded 2016 and 2017 EOCCO 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 measure(s). The incentive measures must be ones that the county is still struggling to meet. Additionally, projects cannot overlap with Opt-In project areas, must be programmatically and financially distinct from all other 2018 applications, and must include a sustainability plan for after funding ends.

Eligible Organizations for Continuing Projects: Grantees from the 2016 or 2017 EOCCO projects.

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

Submission Process: To request EOCCO reinvestment funds, please follow the directions in this Request for Applications (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, and any

required Letters of Commitment. Send your full application in a **single** PDF to Sankirtana Danner at danners@ohsu.edu and Anne King at kinga@ohsu.edu **by 5 pm PDT on January 31, 2017**.

Important Note: You will receive an email indicating that your application has been received. **If you do not receive that email within 24 hours, please contact Sankirtana or Anne.**

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.

Timeline: Applicants should hear about the status of their requests by March 1, 2018. The earliest start date for projects is March 15, 2018 and all projects should end by January 31, 2019.

Technical Assistance: OHSU staff members are available to answer questions and to provide feedback on your project design and evaluation plan. Please contact Sankirtana Danner danners@ohsu.edu or Anne King kinga@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):

__ Adolescent Well Care Visit Event
__ Childhood Immunizations/Developmental Screenings
__ Cigarette Smoking Prevalence
__ Colorectal Cancer Screening
__ Emergency Department Utilization
__ Population Health Management for Hypertension and Diabetes
__Continuing a Current Project

Total Amount Requested (note funding limits): $_____

Project Title: _____

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

Project Summary (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, and any required Letters of Commitment (Appendix 2) using the following guidelines and templates.

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.

Application Questions for All Projects

A. Provide a detailed description of the project plan, including:

I. Project goals
II. Targeted incentive measures
III. A detailed description of the planned activities
IV. A detailed timeline of activities

B. Describe the data you will collect to measure success of your project. Complete the table below, including a description of the baseline data you will use to measure success.

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

*If funded, updates to the EOCCO Board on the status of your project and its metrics will be due with your progress reports during the project year.

C. Please list each member of the project team, their organization, and thoroughly describe their roles and responsibilities on the project. All activities that are proposed in Question A should be represented.

D. 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?

E. What could cause your organization to have trouble with the project and how could you reduce this risk?

F. Please list the organizations involved in your project and submit a Letter of Commitment from each collaborating organization.

G. Describe a detailed plan for sustaining this effort once the project ends.

Opt-In Project Additional Questions

H. Adolescent Well Care Event

I. Describe your proposed event, a plan for developing and staffing the event, how you will use data and conduct outreach to identify and communicate with adolescents needing AWC visits and their parents/guardians, and utilizing incentives and other strategies to encourage AWC completion.

II. In addition to AWC, which Incentive Measures do you plan to target at the event? See Appendix 1 for suggested additional measures.

   a. Describe how you will provide these services, including who will provide the services.
   b. Describe how you will bill EOCCO for the services and who will bill for them.
   c. Submit a Letter of Commitment from any organization that is listed as providing services and/or billing for them.

III. How will you collect the required metrics, including overall attendance at the event, participant satisfaction with the event, and number of services provided to EOCCO and non-EOCCO participants?

I. Childhood Immunizations and Developmental Screenings

I. Describe how you will begin to use ALERT or improve current use.

II. Describe in detail plans to ensure both accurate historical and prospective data are collected in real time into ALERT for all patients.

III. If proposing developmental screenings, which screening tool will be used (see Table 1 in the Opt In description in Appendix 1 for a list of accepted tools)?

IV. If proposing developmental screenings, include the plan to ensure appropriate primary care provider follow up with families and submission of claims.

   a. Submit a Letter of Commitment from any organization that is listed as providing services and/or billing for them.

J. Cigarette Smoking Prevalence

I. What is the estimated number of EOCCO patients who will be reached by this project?

II. Describe the plan to ensure documentation of cigarette smoking prevalence in the electronic health record.

III. What is the proposed workflow for primary care provider counseling, prescribing, follow up and timely submission of claims for tobacco cessation counseling?

   a. Submit a Letter of Commitment from any organization that is listed as providing services and/or billing for them.

IV. State a commitment to track and report the number of patients referred to the Moda Health Coach and additional coaching utilization information.

   a. If the organization referring patients is different from the primary applicant, include a Letter of Commitment from the referring organization stating their commitment to this activity.

V. What training and/or resources do you plan to provide to ensure all parties are able to complete their assigned roles and report screening data?

K. Colorectal Cancer Screening

I. Which clinic(s) will participate in this project (include the names of any clinics who will follow the proposed project plan under the leadership of the primary applicant and whose patients will be mailed a FIT for this project)?
   a. How many EOCCO patients are in each participating clinic?
   a. Include a Letter of Commitment from each participating clinic, confirming their commitment to the use of FITs and following the proposed project plan.

II. Which FIT will be used for the project (Hemosure or OC-Auto)?

III. How will the clinic(s) place orders for the FITs?

IV. Which lab will be used to process the FITs? Include the following:
   a. A letter of commitment from the lab ensuring that the lab will process the FITs for all clinics included in the proposal and will be able to do so for the duration of the project period. Note that if the OC-Auto test will be used, a special processing unit is required and the lab must verify in the letter that they can process this test.
   b. Describe any information the lab will need in order to process the tests and how that information will be provided to the lab.
   c. Describe the workflow for FITs to reach the lab, including whether the FITs will be returned to the clinic and then routed to the lab, or be sent directly to the lab. If sent to the clinic first, describe the staffing and workflow to ensure the kits reach the lab.

V. How will patients receive results and follow up if needed.

VI. Describe how your team will develop clinic-centered patient materials, including patient letters/reminders and education to increase response rate.

L. Emergency Department Utilization

II. Thoroughly describe the planned evidence-based intervention to reduce Emergency Department utilization for physical health visits.

III. Describe the inclusion criteria for the cohort you intend to work with including their physical and mental health and social determinants characteristics. Include the number of EOCCO patients anticipated to be included in the cohort.

IV. Describe the usual care that is provided to this cohort and what you intend to change/add to that care. Include who will provide the services.

V. Describe any integration of services with partnering organizations to address patient access barriers.
   a. Any partnering organization must submit a Letter of Commitment.

VI. If the proposal requests a continuation of a program that has received prior EOCCO funding, describe new progress since submission of the final report.

VII. If the proposal requests a continuation of a prior funded project, describe how the current proposal expands on the prior project or includes a substantial new component.

VIII. How will your project track the following data:
   a. Tracking patients through the life of the project.
   b. Utilization of hospital and primary care services (outpatient, emergency department, observation, inpatient) for the cohort at baseline (12 month lookback), 6 months, 12 months, and 24 months.
   c. Report on utilization by time of day, weekend, and holiday visits (if possible).

M. Population Health Management: Hypertension and Diabetes

I. Which registry will be used for this project (Arcadia or another)?

II. Summarize your current level/stage of connection with the registry and any work done thus far to implement use of this registry into regular clinical workflows.

III. If using a registry other than Arcadia, describe the registry tool and discuss any prior experience using the selected tool for population health management.

IV. If you are in the process of implementing the registry, but are not fully connected, provide a reasonable timeline for completing connection and implementation of your proposed project plan.

Application Instructions for Continuing Current Projects

If you are applying for funds to continue a 2016 or 2017 project, please submit an Application Cover Sheet, a Project Narrative answering the questions listed below, a Budget and a Budget Justification, and Letters of Commitment using the following guidelines and templates.

Project Narrative (up to 5 pages)

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

A. Provide a detailed description of the project plan, including:

I. Project goals
II. Targeted incentive measures
III. A detailed description of the planned activities
IV. A detailed timeline of activities

B. Describe the outcomes and data from your 2016/2017 project that supports continuing this effort in 2018. What has made this incentive measure or measures difficult for your county to improve?

C. What changes do you plan to make to your project compared to 2016/2017 and what has led you to these changes?

D. Describe the data you will collect to measure success of your project. Complete the table below to summarize this plan.

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

*If funded, updates to the EOCCO Board on the status of your project and its metrics will be due with your progress reports during the project year.

E. Please list each member of the project team, their organization, and thoroughly describe their roles and responsibilities on the project. All activities that are proposed in Question A should be represented.

F. 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?

G. What could cause your organization to have trouble with the project and how could you reduce this risk?

H. Please list the organizations involved in your project and submit a Letter of Commitment from each collaborating organization.

I. Describe a detailed plan for sustaining this effort once the project ends.

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.

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

Adolescent Well Care Visits Event

Background

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. Thanks to strong efforts by organizations and clinics in eastern Oregon, particularly through the grant program, EOCCO exceeded their target for this measure with a final rate of 35.1%

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 and school-based health center workflows 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; use of community health workers for patient education and outreach; and reducing barriers by offering evening appointments or transportation assistance. Based off of previously successful AWC efforts, the 2017 grant cycle 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 their plan to develop and staff the event using data and *targeted* outreach to identify and communicate with adolescents (including older teens in the 18-21 age range) needing AWC visits and their parents and utilize 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 should provide a plan for billing for the AWC visit and additional services applicable to this age group, including depression screening and dental sealants. Preference will be given to plans that include multiple measures.

Participants

Applicants and collaborators may include: clinics, hospitals, health departments, school-based health centers, and local community advisory councils.

County-wide collaboration is encouraged as a maximum of one grant per county will be awarded.

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 4.

- Project plans must include offering 3 or more services at the event, including the AWC visit, depending on the target age group. At a minimum, events should also include depression screening and dental sealants and bill for these services.

    - Applicants are strongly encouraged to also consider addressing effective contraceptive use, childhood obesity, developmental screenings, childhood immunizations, and cigarette smoking. Project plans should address how the event will provide billable services and/or offer education in such a way that EOCCO will qualify for credit toward the targeted incentive measures (see OHA guidance: http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx)

- Documented collaboration and commitment from providers for the planned services must be included in the application, including a description of workflows within the project plan and letters of support from any organizations who demonstrate commitment to offering services. Proposals that lack this documentation will not meet the minimum requirements.

- 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 members and non-EOCCO participants.

- Applicants should review the OHA Guidance on the proposed incentive measures to ensure the planned event has the desired impact: http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx

- Detailed plan for sustaining this activity once funding has ended

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.

- Depression screening and follow-up plan
- Dental sealants on permanent molars for children
- Effective contraceptive use among women at risk of unintended pregnancy
- Developmental screenings in the first 36 months of life
- Childhood immunization status
- Cigarette smoking prevalence
- Childhood obesity

Award

Up to $40,000 per application. Acceptable costs include funds to pay for contracted clinic staff, general staffing, event planning, materials and incentives. Cost effectiveness of events will be considered in funding decisions.

Childhood Immunizations and Developmental Screenings

Background

Age-appropriate vaccination is key to preventing disease, yet many children do not receive timely immunizations. Effective strategies to improve timely immunization rates include parent reminders and recalls and provider reminders, education and feedback programs. (Williams, 2011) The CCO Childhood Immunization Status Incentive Measure is intended to improve immunization rates and timeliness of vaccinations for children under two years of age. The measure's denominator is all children who turned two years of age during the measurement year and its numerator is those children who had all of the following vaccinations on or before their second birthday:

- DTaP- at least four DTaP (DTaP Vaccine Administered Value Set)
- IPV- at least three IPV vaccinations (Inactivated Polio Vaccine Administered Value Set) with different dates of service
- MMR- Any of the following: At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set), OR one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set), OR one measles vaccination (Measles Vaccine Administered Value Set), OR one mumps vaccination (Mumps Vaccine Administered Value Set), OR one rubella vaccination (Rubella Vaccine Administered Value Set).

Immunization data must be captured in the State of Oregon's immunization registry called ALERT. More information on the measure including evidence-based strategies and instructions for ALERT report patients who are not up-to-date on vaccinations can be found in the CCO Resource Guide for immunizations: http://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/Childhood%20Immunization%20Status%20-%202017%20(revised%20Jul%202017).pdf

Developmental Screenings

In addition to childhood immunizations for children under two, another important area of focus for this age group is developmental screenings for ages zero to three. Proposals that aim to address both of these areas are allowed for this opportunity and can request an additional $10,000.

Many development screening tools exist but only some meet the Oregon Health Authority requirements based on psychometric properties, appropriateness for general screening, and feasibility of implementation in primary care settings. In addition to use of appropriate tools, a crucial component of development screening includes parent engagement to understand screening results. The following criteria must be met for inclusion in this measure:

- The tool used must be an accepted tool as indicated in Table 1. Note that the ASQ is the preferred tool.
- A provider (physician, NP, or PA) within the provider network must review the results in the context of a clinical visit, interpret the findings with the family, and document the tool used, the results, and actions taken appropriately in the patient record within one month of the completed screen
- A claim for CPT code 96110 must be submitted to EOCCO

Table 1. Developmental screening tools (OHA, Developmental Screening for Young Children Guidance Document)

Tool	Preferred	Accepted	Not Accepted	Not Appropriate for General Screening
Ages and Stages Questionnaires, Third Edition (ASQ-3)	X	X		
Parents Evaluation of Developmental Status (PEDS)		X		
ASQ-SE			X	X
M-CHAT			X	X
Battelle Developmental Inventory Scoring Tool (BDI-ST)		X		
Bayley Infant Neuro Developmental Screening (BINS)		X		
Brigance Screens –II		X		
Child Developmental Inventory (CDI)		X		
Infant Development Inventory		X		
Developmental surveillance milestones within Bright Futures and the Bright Futures Implementation Guide Pre-Visit Forms			X	

Project Plan

Proposed projects may either focus on:

1. Childhood immunizations, or
2. Childhood immunizations and developmental screenings

Below are project plan descriptions for either option.

Childhood Immunizations Only

Proposed projects should focus on increasing immunization rates and timeliness of vaccinations for children under two years of age. Potential projects could include the following:

- Implementing ALERT for the first time into the electronic health record, into workflows in a clinical setting and entering historic data
- Collaborations between public health and primary care to ensure timely immunizations and continuously updated ALERT data
- Implementing evidence-based strategies in clinical settings, such as: provider guidance to parents regarding timely immunizations, standing orders, immunization-only appointments, expanded clinic hours and walk-in immunization appointments, patient reminder and recalls, provider-specific immunization metrics, forecasting and scheduling changes and increasing awareness of optimal vaccine schedules, as well as other strategies described in the CCO Resource Guide.

Childhood Immunizations and Developmental Screenings

Proposed projects should focus on any of the above suggestions to increase childhood immunization rates and timeliness of vaccinations for children under two years of age. The addition of developmental screening should include proposals to increase development screening rates for children in the first 36 months of life through collaboration between family and community support systems and health care providers, provision of training and resources to increase implementation, or other similar efforts. Examples include:

- **Training and Resources:** Collaborations between early learning intervention specialists and health care providers to distribute ASQ resources and/or offer training/support to integrate ASQ into clinic workflows
- **Awareness Campaigns:** Efforts between early learning, early intervention, pre-schools and public schools, public health, and primary care clinics to increase awareness, collaboration, and implementation of development screening
- **Information Sharing:** Efforts to promote collaboration between early learning and primary care through information sharing via medical systems and/or assigning care coordinators to monitor screenings and ensure proper follow up

Participants

Primary care clinics and public health departments are eligible to apply as lead organizations. Collaboration between public health, primary care and community agencies is encouraged. Proposals that include developmental screening may also include early learning and early childcare providers.

Applicant Requirements

- Applications must include use of ALERT and describe in detail plans to ensure both accurate historical and prospective data are collected in real time into ALERT for all patients.
- Letter of Support from all collaborators describing their roles and commitment to the project plan
- Review the OHA guidance documents for any targeted measures: http://www.oregon.gov/OHA/HPA/ANALYTICS/Pages/CCO-Baseline-Data.aspx (Childhood Immunizations; Developmental Screenings)
- Applications that include developmental screening must also include a plan to ensure appropriate primary care provider follow up with family and submission of claim
- Detailed plan for sustaining this activity once funding has ended

Metrics

- Childhood Immunization Status
- Developmental Screenings in the first 36 months of life

Award

Childhood Immunizations Only: up to $25,000 per application
Childhood Immunizations and Developmental Screenings: up to $35,000 per application

Reducing Cigarette Smoking Prevalence

Background

Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States. (Prevention, 2017) The cost of smoking-related illness exceeds $300 billion each year in the United States. According to Oregon Health Authority, 95 percent of adult smokers start smoking before age 21. Many adult cigarette smokers want to quit smoking. (Prevention, Economic Trends in Tobacco, 2017)
The purpose of this Opt In project is to reduce the prevalence of tobacco use, ensure prevalence data is being captured in electronic health records, and encourage the use of cessation benefits among EOCCO members. This incentive measure has been updated for 2018 to include reducing prevalence while still capturing and reporting EHR-based cigarette smoking and tobacco use prevalence data. Funds will support evidence based strategies and community collaborations to reduce prevalence.

Applicants should review the OHA Guidance on the proposed incentive measure:
Cigarette Smoking Prevalence (Bundled Measure)

Project Plan

Applicants must propose projects focusing on reducing the prevalence of tobacco use, ensuring prevalence data is being captured in electronic health records, and encouraging use of EOCCO cessation benefits for individuals ages 13 and up through evidence-based interventions.

Projects should focus on clinical settings to reduce prevalence and support cessation efforts through: documentation in medical record and claims submissions (Medical Coding: 99406 – brief visit, <10 minutes; 99407 – Intensive visit if quit date is documented (10 sessions every 3 months), and/or NRT), referral process to Tobacco Quit Coach at MODA, provider support of quitting tobacco and offering Nicotine Replacement Therapy (NRT), and tobacco cessation counseling referrals with a Tobacco Quit Coach.

Optional Additions: 1) Clinic-community awareness campaigns that support reducing tobacco prevalence in the community, such as: text messaging programs and tobacco cessation counseling with a Tobacco Quit Coach at MODA. 2) Health System-Public Health collaborations to reduce tobacco prevalence, such as encouraging community tobacco free sites and policies to support tobacco cessation.

Applicants should describe in their plan which organizations and staff members will contribute to the cessation efforts, how collaboration between organizations will be monitored and optimized, proposed workflows for primary care provider follow up and billing, and any training or resources that would be necessary to ensure all parties are able to complete their assigned roles and report screening data.

Participants

Applicants and collaborators may include: primary care clinics, public health departments, dental clinics, behavioral health agencies, and community organizations.

Applicant Requirements

Applicants should include in their proposals:

- An estimate of the number of EOCCO members expected to be reached by the project.
- A plan to document and report on cigarette prevalence in the electronic health record.
- A plan to ensure appropriate primary care provider follow up and timely submission of claims for tobacco cessation counseling.
- An agreement to track and report the number of patients referred to the MODA Health Coach and additional coaching utilization information.
- Applicants should review the OHA guidance to ensure proposed activities will quality for credit toward the cigarette smoking incentive measure.
- Letters of support from all collaborators describing their roles, funding received, if any, and commitment to the project plan.
- Describe detailed plan for sustaining this activity once the funding has ended.

Metrics

The measure calls for a report of three rates: (1) the rate of patients who had cigarette smoking or tobacco use status recorded, and then of the patients with recorded status, (2) the rate of patients who are cigarette smoking and (3) the rate who are cigarette smokers and/or tobacco users. Although OHA prefers to have both rates 2 and 3 reported, the prevalence rate is calculated based on rate 2, and we will accept data submissions that do not include rate 3.

Award

Up to $25,000 per grantee.

Colorectal Cancer Screening Proposal Synopsis

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. EOCCO has had considerable difficulty meeting the benchmark for CRC screenings, failing in 2015 and barely passing in 2016. In the meantime, our benchmark targets increase each year.

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 (Fecal Immunochemical Test) mailing program and patient-centered 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 Hemosure or OC-Auto FITs to EOCCO patients who are due for CRC screening according to US Preventive Task Force recommendations. Clinics may choose which type of test (Hemosure or OC-Auto) they wish to use. EOCCO representatives will produce a list of patients eligible for screening by clinic, and work with clinics to finalize this listing. 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 on a regular basis. FIT tests will be returned to the patient's clinic for routing to the laboratory of the clinic's choice, or directly to the laboratory. Follow up calls will be provided by the vendor centrally, and callers will let patients know that they are calling on behalf of their doctor's office.

Patient Educational Outreach: 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.

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.
- Clinic point of contact: This individual and their implementation team from the clinic will be responsible for working with the EOCCO representative to review the list of eligible patients. The point of contact will also manage customization of patient materials and provide logos/letterhead to ensure that direct mail materials are clinic-centered. They will also develop a process to coordinate follow up colonoscopies for abnormal FIT screening results
- LCAC, PFAC, or other community partner(s): Will work with the clinic partner to create 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.

Metrics

- Colorectal cancer screening

Budget

Up to $25,000 per grantee

Emergency Department Utilization

Purpose

Helping patients get care "at the right time and in the right place" is core to the CCO Incentive Measure Ambulatory Care: Emergency Department utilization. Past EOCCO-funded projects have successfully reduced inappropriate use of emergency departments by increasing access to same-day primary care visits, developing shared 24-hour call services across small rural clinics, and embedding traditional healthcare workers and behavioral health workers into emergency and primary care settings. New to the measure in 2018 is an additional emphasis on patients with mental illness, however, the Incentive Measure still refers only to reductions of emergency department utilization for physical health visits.

Evidence suggests that factors contributing to inappropriate emergency department utilization by adults include: difficulty accessing primary care, challenges setting up appointments, longer waiting periods for appointments, and shorter business hours of primary care clinics. (Carret, 2009) Frequent emergency department utilization is driven by patient characteristics (low socioeconomic status, higher disease burden, younger age) and system characteristics (lack of access, lack of coordination across providers, insufficient mechanisms to ensure patients have annual checkups, convenience compared to alternatives). (Hudon C, 2016) (Uscher-Pines, 2013)

Project Plan

Applicants should propose an evidence-based intervention to reduce Emergency Department utilization for physical health visits. Projects should identify and follow a cohort of patients, apply an evidence-based intervention, and measure the results. Applicants are encouraged to include in their projects:

1. Collaborations between hospitals, behavioral health providers and/or primary care clinics to increase and reduce barriers to access, coordinate care, integrate new services or workflows, and
2. Interventions that target patients with mental health/behavioral health needs and/or multiple chronic conditions.

Projects that include integration of services of partnering organizations to address patient access barriers are encouraged. Applicants that have received prior funding in this area are eligible to apply again, however, the 2018 proposal should include a major expansion of the prior project or a substantial new component not previously included.

Participants

Applicants may include: hospitals, primary care and behavioral health organizations

Applicant Requirements

Participating organizations are encouraged to use PreManage to help identify a cohort of EOCCO patients to include in the intervention, to track these patients throughout the life of the project, and report baseline utilization and change in utilization at 6, 12 and 24 months. The intervention should be designed to last 12 months.

Metrics

Required metrics include utilization of hospital and primary care services (outpatient, emergency department, observation, inpatient) for the cohort at baseline (12-month look-back), 6 months, 12 and 24 months. Applicants are encouraged to report on utilization by time of day, weekend, and holiday visits.

Award: Up to $50,000 may be requested.

Population Health Management:
Controlling High Blood Pressure/ Diabetes: HbA1c Poor Control

Purpose

This Opt-In project is intended to support the application of population health management tools to track and control high blood pressure and diabetes in a patient population. EOCCO has engaged Arcadia Healthcare Solutions 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 is intended to help primary care practices 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 between EOCCO and Arcadia provides for assistance with a 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.

This project will provide support for clinics that are working with Arcadia, or for those clinics proposing an alternative registry to Arcadia, towards designing a population health management project aimed at addressing uncontrolled high blood pressure and diabetes.

Applicants should review the OHA guidance on the incentive measures:
Controlling High Blood Pressure
Diabetes: HbA1c Poor Control

Project Plan

Applicants should propose a project to use Arcadia or an alternative method to build one or more registries and use the tool for population health management in daily activities. Proposed projects should focus on increasing measure outcomes by proactively managing patients with chronic conditions, specifically hypertension and diabetes.

1. Build the registry and framework by developing workflows and train the team to use the registry.
2. Population Health Management: Using Arcadia or another option, implement evidence based strategies to proactively manage patients.

Additional resources:
https://www.stepsforward.org/modules/point-of-care-registry
http://www.arcadiasolutions.com/

Participants

Eligible participants include primary care practices or health systems.

Applicant Requirements

Clinics that have implemented Arcadia Analytics are encouraged to apply. Those that are in the process of implementing Arcadia should provide a reasonable timeline for implementation that includes sufficient time to complete their project. For clinics that wish to use alternate registries, please describe the registry tool and discuss any prior experience using the selected tool for population health management.

Metrics

While the **Controlling High Blood Pressure** and **Diabetes: HbA1c Poor Control** are the primary targets for this proposal, other measures to include are:

- Cigarette Smoking Prevalence
- Colorectal Cancer Screening
- Depression Screening and Follow Up Plan
- Timeliness of Prenatal Care
-

Award

Up to $30,000 per grantee.

Appendix 2
Letter of Commitment 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
Eastern Oregon Coordinated Care Organization 2018 Incentive Measure Dictionary

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.

Claims Based Measures:

	Measure Definitions	Data Source
1	**Adolescent Well Care Visits** Adolescents ages 12-21 with at least one comprehensive well care visit. Well care visit includes: • History • Physical exam that includes weight, height, vision, heart, lungs, skin and genitalia • Assessment & plan	Medical claims
2	**Alcohol and Drug Misuse Screening** (SBIRT) Members ages 12 and older who received alcohol and drug misuse screening during an outpatient visit. Outpatient visits include office visits, home visits, 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
3	**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 (ALERTIIS)
4	**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). • Ages 1-4 mental health assessment not required • Ages < 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
5	**Dental Sealants on Permanent Molars for Children** 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
6	**Developmental Screening (0-36 months)** Children who turn 12 months, 24 months, or 36 months in 2018 who had a developmental screening within the 12 months prior to their birthday. 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	Medical claims

	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.	
7	**Effective Contraceptive Use** Women ages 15-50 with evidence of one of the following methods of contraception in 2018: 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 (LARC) or permanent contraceptive options who would not otherwise have a pharmacy claim or procedure code in 2018.	Medical and pharmacy claims
8	**Emergency Department Utilization** Patients who have a physical health visit at an ED that does not result in an inpatient encounter. Exclude ED visits with a primary diagnosis of mental health or chemical dependency. Multiple ED visits on the same date of service is counted as 1 visit.	Medical claims
9	***Emergency Department Utilization for Individuals Experiencing Mental Illness** Patients with a previous diagnosis of mental illness who have a physical health visit at an ED that does not result in an inpatient encounter. Exclude ED visits with a primary diagnosis of mental health or chemical dependency. Multiple ED visits on the same date of service is counted as 1 visit.	Medical claims
10	***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents** Patients ages 3-17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement period: 1. Height, weight, and body mass index (BMI) documented 2. Nutrition Counseling 3. Physical Activity Counseling	To be determined

***New measures in 2018**

State CAPHS Survey Measures

	Measure Definitions	Data Source
11	**CAHPS Access to Care** • Received care right away for illness/injury/condition as soon as you/child needed • Received an appointment for routine care as soon as you/child needed	State CAHPS survey

Chart Review Measures

	Measure Definitions	Data Source
12	**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
13	**Timeliness of Prenatal and Postpartum Care** Prenatal care provided in the first trimester or within 42 days of enrollment. First trimester is considered the first three months of pregnancy, from the first day of the last menstrual period	Medical claims and chart review on

	through 13 weeks gestation. Prenatal care 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) Postpartum care Evidence of one of the following between 21 and 56 days after delivery: • 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	sample population, determined by Oregon Health Authority

Clinical Quality Measures

	Measure Definitions	Data Source
14	**Cigarette Smoking Prevalence** Unique members 13 years of age 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. Rate # 2 is used to determine the cigarette smoking prevalence measure. The rate must reduce in 2018. **Reports must be able to query the following to determine the <u>prevalence</u> measure:** 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? Rate # 2 is used to determine the cigarette smoking prevalence measure. The rate must reduce in 2018. For information on tobacco treatment reimbursement, please refer to the EOCCO provider manual http://eocco.com/providers/resources.shtml	Clinic's Electronic Health Record
15	**Controlling Hypertension (High Blood Pressure)** Patients ages 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
16	**Depression Screening and Follow Up Plan** Patients ages 12+ screened for clinical depression, using an age appropriate	Clinic's Electronic

	standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Health Record
17	**Diabetes HbA1c Poor Control** Patients ages 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

PCPCH Enrollment Measure

	Measure Definitions	Data Source
18	**PCPCH Enrollment** Number of members enrolled in PCPCHs by tier.	EOCCO Member PCP assignment

Appendix 4
EOCCO Incentive Measure Reference Guide 2018

Claims Based Measures:

	Metric	Code(s) and Identification	Notes
1	**Adolescent Well-Care Visits**	Annual adolescent well-care visit includes history, physical, assessment & plan. **CPT/HCPCS Codes** 99383-99385, 99393-99395, G0438, G0439 **ICD-10-CM Diagnosis** Z00.00, Z00.01, Z00.121, Z00.129, Z00.5, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.71, Z02.79, Z02.81, Z02.82, Z02.83, Z02.89, Z02.9	Members ages 12-21 years old receiving at least one comprehensive well care visit during the measurement year.
2	**Alcohol and Drug Misuse Screening** (SBIRT)	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 96160, 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 96160 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.

<table>
<tr>
<td>3</td>
<td>Childhood Immunization Status 2</td>
<td>
<table>
<tr><th>Type</th><th>Required</th><th><u>CVX</u></th><th><u>Codes & Diagnoses</u></th></tr>
<tr><td>DTaP</td><td>At least four</td><td>20, 50, 106, 110, 120</td><td>90698, 90700, 90721, 90723</td></tr>
<tr><td>IPV</td><td>At least three</td><td>10, 110, 120</td><td>90698, 90713, 90723</td></tr>
<tr><td rowspan="4">MMR (Measles, Mumps and Rubella)</td><td rowspan="4">At least one or history of measles, mumps, or rubella illness</td><td>MMR: 03, 94</td><td>90707, 90710</td></tr>
<tr><td>Measles/Rubella: 04</td><td>90708</td></tr>
<tr><td>Measles: 05</td><td>90705
B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9</td></tr>
<tr><td>Mumps: 07</td><td>90704
B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9</td></tr>
<tr><td></td><td>Rubella: 06</td><td>90706
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>46-51, 120, 148</td><td>90644, 90645-90648, 90698, 90721, 90748</td></tr>
<tr><td>Hepatitis B</td><td>At least three or history of hepatitis illness</td><td>08, 44, 51, 110</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 Vaccine Administered</td><td>At least one</td><td>21, 94</td><td>90710, 90716</td></tr>
<tr><td>Varicella Zoster</td><td>history of varicella zoster</td><td></td><td>B01.0, B01.1, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9,</td></tr>
</table>
</td>
<td>Members who turn 2 years of age during 2018.

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

Note: EOCCO relies on the Public Health Division Program Registry (ALERTIIS) data.</td>
</tr>
</table>

			(e.g., chicken pox) illness		B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.32, B02.22, B02.33, B02.34, B02.49, B02.7, B02.8, B02.9	
4	**Dental, Mental, Physical Health Assessment 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 **<u>Physical Health Assessment Codes</u>** 99201-99205, 99212- 99215, 99381-99384, 99391-99394, G0438, G0439 **<u>Mental Health Assessment Codes</u>** 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) **<u>Dental Health Assessment Codes</u>** D0100-D0199			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) or 30 days prior. 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>5</td>
<td>Dental Sealants on Permanent Molars for Children</td>
<td><u>Dental Sealant HCPCS Code</u>
D1351

**Dental hygienists can determine the need for and apply sealants without the supervision of a dentist.</td>
<td>Members age 6-14 who receive a sealant on a permanent molar tooth.</td>
</tr>
<tr>
<td>6</td>
<td>Developmental Screening (0-36 months)</td>
<td><u>Developmental Screening CPT Code</u>
96110</td>
<td>Members who turn 12, 24, or 36 months in 2018. Screening must be completed 12 months prior to the member’s birthday.</td>
</tr>
<tr>
<td>7</td>
<td>Effective Contraceptive Use</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, J7301, J7302, vS4989, Q0090, S4981</td></tr>
<tr><td>Hormonal implant</td><td>Z30.016, Z30.017</td><td>11981, 11983</td><td>J7306, J7307,</td></tr>
<tr><td>Injectable (1-month/3-month)</td><td>Z30.013,</td><td></td><td>J1050, J1051, J1055, J1056</td></tr>
<tr><td>Oral contraceptive</td><td>Z30.011</td><td></td><td>S4993</td></tr>
<tr><td>Patch</td><td>Z79.3</td><td></td><td>J7304</td></tr>
<tr><td>Vaginal ring</td><td>Z30.015</td><td></td><td>J7303</td></tr>
<tr><td>Diaphragm</td><td></td><td>57170</td><td>A4266</td></tr>
<tr><td>Surveillance of a contraceptive method</td><td></td><td>Z30.41, Z30.42, Z30.44, Z30.45, Z30.46, Z30.49</td><td></td></tr>
</table>
</td>
<td>Women age 15-50 at risk for unintended Pregnancy.

Exclusions:
Women in the denominator who were not numerator compliant and had a pregnancy diagnosis in the calendar year.</td>
</tr>
</table>

Unspecified Contraception		Z30.019, Z30.018, Z30.40, Z30.8, Z30.9	

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 2018

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: See HEDIS 2018 Pregnancy Diagnosis Value Set (178 codes) Z34.00, Z34.80, Z34.90, Z33.1, Z32.01, Z64.0 **Pregnancy CPT Codes:** See HEDIS 2018 Pregnancy Diagnosis Value Set (1,692 codes)59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, 59425, 59426

Exclusions (ICD-10s):

Hysterectomy Diagnosis
ICD-9 Dx Codes
V45.77, V88.01, V88.02
ICD-9 Procedure Codes
68.31, 68.39, 68.41, 68.49, 68.51, 68.59, 68.61, 68.69, 68.71, 68.79, 68.9, 66.31, 66.32, 66.39, 66.51, 66.52
ICD-10 Dx Codes
Z90.710, N99.3, Z90.711, Z90.722
CPT/HCPCS
51925, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275,

		58280, 58285, 58290, 58291-58294, 58541-58544, 58548, 58550, 58552-58554, 58570-58573, 58943, 58950-58954, 58956-58958, 59135, 59525 **Bilateral Oophorectomy Procedures** 0UT20ZZ, 0UT27ZZ, 0UT28ZZ, 0UT2FZZ, 0UT00ZZ, 0UT08ZZ, 0UT0FZZ, 0UT10ZZ, 0UT17ZZ, 0UT18ZZ, 0UT1FZZ, 0UT24ZZ, 0UT04ZZ, 0UT14ZZ, 0U520ZZ, 0U523ZZ, 0U524ZZ, 0U570ZZ, 0U573ZZ, 0U574ZZ, 0U577ZZ, 0UB20ZZ, 0UB23ZZ, 0UB24ZZ, 0UB27ZZ, 0UB28ZZ, 0UB70ZZ, 0UB73ZZ, 0UB74ZZ, 0UB77ZZ, 0UB78ZZ, 0UL70CZ, 0UL70DZ, 0UL70ZZ, 0UL73CZ, 0UL73DZ, 0UL73ZZ, 0UL74CZ, 0UL74DZ, 0UL74ZZ, 0UL77DZ, 0UL77ZZ, 0UL78DZ, 0UL78ZZ, 0UT07ZZ, 0UT40ZZ, 0UT44ZZ, 0UT47ZZ, 0UT48ZZ, 0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ, 0UT90ZZ, 0UT94ZZ, 0UT97ZZ, 0UT98ZZ, 0UT9FZZ **Natural Menopause Diagnosis** N92.4, N95.0, N95.1, N95.2, N95.8, N95.9, Z78.0 **Premature Menopause Diagnosis** 256.1, 256.2, 256.31, 256.39, 256.8,E89.40, E89.41, E28.310, E28.319, E28.39, E28.8, E28.9, N98.1 **Congenital Anomalies of Female Genital Organs Diagnosis** Q50.02, Q51.0 **Female Infertility Diagnosis** 628.0, 628.2, 628.3, 628.4, 628.8, 628.9, N97.0, N97.1, N97.2, N97.8, N97.9	
8	**Emergency Department Utilization**	Count each visit to an ED that does not result in an inpatient encounter; count multiple ED visits on the same date of service as one visit. Do not include ED visits that result in an inpatient stay. **ED Value Set CPT Codes** 99281-99285 **UB Revenue** 0450, 0451, 0452, 0456, 0459, 0981 **ED Procedure Code Value Set with ED POS Value Set** 10021-69990 with 23	**Exclusions:** **Inpatient Stay Visits Value Set** 0100, 0101, 0110-0114, 0116-0124, 0126-0134, 0136-0144, 0146-0154, 0156-0160, 0164, 0167,

		Ambulatory Outpatient Visits CPT Codes 92009, 92004, 92012, 92014, 99201-99205, 99211-99215, 99247-99328, 99334-99337, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99461 **Ambulatory Outpatient Visits HCPCS Codes** G0463, T1015 **Ambulatory Outpatient Visits UBREV Codes** 0510-0517, 0519-0529, 0982, 0983	0169-0174, 0179, 0190-0194, 0199-0204, 0206-0214, 0219, 1000-1002 Mental health and chemical dependency services are excluded from the numerator.
9	***Emergency Department Utilization for Individuals Experiencing Mental Illness**	Patients with a mental illness diagnosis noted on two or more claims in the last 36 months (January 1, 2016 to December 31, 2018) are in the denominator. Patients with a physical health visit in the ED that does not result in an inpatient encounter are in the numerator. Count multiple ED visits on the same date of service as one visit. Do not include ED visits that result in an inpatient stay. **Mental Illness Value Set** F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F21, F23, F24, F25.0, F25.1, F25.8, F25.9, F28, F29, F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.8, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.8, F34.9, F39, F42, F43.10, F43.11, F43.12, F60.3 **ED Value Set CPT Codes** 99281-99285 **UB Revenue** 0450, 0451, 0452, 0456, 0459, 0981 **ED Procedure Code Value Set with ED POS Value Set** 10021-69990 with 23	Mental health and chemical dependency services are excluded from the numerator. **Exclusions:** **Inpatient Stay Visits Value Set** 0100, 0101, 0110-0114, 0116-0124, 0126-0134, 0136-0144, 0146-0154, 0156-0160, 0164, 0167, 0169-0174, 0179, 0190-0194, 0199-0204, 0206-

			0214, 0219, 1000-1002 **<u>Psychiatry Value Set</u>** 90785, 90791, 90792, 90832 - 90834, 90836 - 90840, 90845 - 90847, 90849, 90853, 90863, 90865, 90867 - 90870, 90875, 90876, 90880, 90882, 90885, 90887, 90889, 90899 **<u>Electroconvulsive Therapy Value Set</u>** GZB4ZZZ, GZB0ZZZ, GZB1ZZZ, GZB2ZZZ, GZB3ZZZ
10	***Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents**	**<u>Outpatient Visits</u>** 99201-99205, 99211-99215, 99217-99220, 99241- 99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456 **<u>UB Revenue</u>** 051x, 0520-0523, 0526-0529, 077x, 0982, 0983 **<u>Nutrition Counseling CPT</u>** 97802-97804	Patients ages 3-17 who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI, Nutrition Counseling, and Physical Activity

		Nutrition Counseling HCPCS G0270-G0271, S9449, S9452, S9470 **Physical Activity Counseling HCPCS** S9451	Counseling. **Exclusions:** Female members who have a diagnosis of pregnancy in 2018.

***New measures in 2018. Code sets are currently draft.**

State CAPHS Survey Measures

	Metric	Code(s) and Identification	Notes
11	**CAHPS Access to Care**	Members surveyed after the calendar year and their response rate to the following statements: • Received care right away for illness/injury/condition as soon as you/child needed • Received an appointment for routine care as soon as you/child needed	Members must have 6 months experience with Medicaid/OHP to be eligible.

Chart Review Measures

	Metric	Code(s) and Identification	Notes
12	**Colorectal Cancer Screening**	**Colonoscopy CPT Codes** 44388-44394, 44397, 44401-44408, 45355, 45378-45387, 45388-45390, 45391, 45392, 45393, 45398 **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,	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,

		27926-5, 29771-3, 56490-6, 56491-4, 57905-2, 58453-2, 80372-6 **Flexible Sigmoidoscopy CPT** 45330-45335, 45337-45342, 45345, 45346, 47347, 45349, 45350 **Flexible Sigmoidoscopy HCPCS** G0104 **DX Codes** 45.24 **CT Colonography CPT Code** 74263 **FIT-DNA CPT Code** 81528 **FIT-DNA HCPCS Code** G0464 **FIT-DNA LOINC Codes** 77353-1, 77354-9 **A pathology report that indicates the type of screening and the date when the screening was performed meets criteria for inclusion in the measure.	Z85.048 **Colectomy CPT** 44150-44153, 44155-44158, 44210-44212 **Colectomy ICD-10** 0DTE0ZZ, 0DTE4ZZ, 0DTE7ZZ, 0DTE8ZZ
13	**Timeliness of Prenatal and Postpartum Care**	**Prenatal care (one of the following)** 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) **Postpartum care (one of the following)** • 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	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, and midwives and

			provided a co-signature by a physician is present, if required by state law.

Clinical Quality Measures

	Metric	Code(s) and Identification	Notes
14	**Cigarette Smoking Prevalence**	**Documentation:** Each EHR may have different codes to document cigarette smoking and tobacco use. 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	Members age 13+ who had a qualifying visit where their smoking and/or tobacco use status is recorded as structured data, who are current smokers and or tobacco users. The prevalence of cigarette smokers is determined by rate #2 and must begin to reduce.
15	**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	Members 18-85 years of age who had a diagnosis of essential hypertension within the first six months 2018 or any time prior and

		or renal transplant, Diagnosis of pregnancy **If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the	who received a qualifying outpatient service in 2018.
16	**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) Note: the follow up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."	Members age 12+ with at least one eligible encounter in 2018. **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

		Also note that the use of PHQ9 is allowable as follow up to a positive PHQ2	health (Medical or Other reason not done Value Set) are considered excluded from the denominator.
17	**Diabetes: HbA1c Poor Control**	Patients whose most recent HbA1c level (performed during 2018) is >9.0%, if the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during 2018. **HbA1c Test CPT Codes** 83036, 83037, 3044F, 3045F, 3046F **LDL-C Test CPT Codes** 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	Members 18-75 years of age who had a diagnosis of diabetes during or any time prior to 2018 and who received a qualifying outpatient service during 2018.
18	**PCPCH Enrollment**	**Numerator:** Number of CCO members enrolled in PCPCHs by tier, using the following formula: (Tier 1 members*1) + (Tier 2 members*2) + (Tier 3 members*3) + (Tier 4 members *4) + (5 STAR members *5) **Denominator:** Total CCO enrollment for the same month as the PCPCH enrollment multiplied by 5.	No exclusions.

Appendix 5

Progress Report- County Summary
December 2016
Reporting Period: Services Incurred 1/1/2016-12/31/2016 as of 3/31/2017

Measure Compliance Rate								
County	Adolescent Well Care Visits	SBIRT	Ambulatory Care & ED Utilization	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Colorectal Cancer Screening**	Childhood Immunization Status
Baker	32.4%	4.7%	53.9	14.9%	68.1%	47.0%	34.7%	68.9%
Gilliam	31.7%	9.8%	43.0	22.0%	18.8%	35.7%	18.5%	20.0%
Grant	35.1%	14.9%	74.1	31.6%	39.0%	28.2%	24.5%	65.2%
Harney	22.7%	22.4%	49.5	11.8%	75.5%	53.8%	36.7%	63.9%
Lake	16.9%	6.7%	45.6	28.6%	33.8%	38.9%	21.7%	55.0%
Malheur	41.5%	12.3%	59.7	21.8%	79.4%	46.5%	38.0%	79.4%
Morrow	42.6%	31.2%	51.4	33.6%	31.4%	50.2%	33.8%	80.0%
Sherman	36.8%	17.9%	45.9	16.7%	35.7%	46.4%	29.3%	66.7%
Umatilla	32.7%	16.3%	59.6	18.4%	36.6%	44.1%	37.6%	71.7%
Union	36.9%	29.9%	62.7	6.6%	82.3%	46.1%	34.2%	57.1%
Wallowa	39.4%	9.5%	29.9	5.3%	67.6%	38.8%	39.4%	78.9%
Wheeler	29.6%	42.6%	30.1	15.2%	58.3%	57.7%	34.9%	75.0%
EOCCO	35.1%	16.9%	57.2	18.6%	54.2%	44.9%	35.2%	70.8%
EOCCO Target	**29.1%**	**11.8%**	**51.5**	**17.4%**	**47.7%**	**42.7%**	**39.0%**	**74.1%**