OHA Transformation and Quality Strategy (TQS) **CCO:** Cascade Health Alliance

Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. **Project short title**: Food Hub: Mill Addition Neighborhood, Klamath Falls

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

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

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☒ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

In the last year and a half, ensuring children, families, adults, and seniors have access to food has been a top priority of Klamath County local schools, local governments, civic groups, and CHA staff.

As schools began to deploy distance learning tactics, ensuring children had access to breakfast, lunch, and snack meals was a must. The Child Hunger Coalition began working with local cafeteria staff and civic groups to create food pick-up and distribution sites. At each distribution site, families could come and pick-up enough food for an entire week to feed their children breakfast, lunch, and two snacks a day for seven days. Distribution sites were located at all 11 neighborhood parks; all elementary, middle, and high school parking lots; and three community centers. Distribution sites were intended to create easy walking access to all children and families.

Ensuring Seniors had access to food was also a high priority in Klamath County. Due to COVID-19, the demand for meals to Seniors increased by more than 60% from the last three years. In response to this demand, CHA donated $50,000 to the Klamath Basin Senior Citizens Center in support of their Meals on Wheels program. This program provided 77,000 meals to 3700 senior residents.

Sanford Children's Clinic collaborated with the Healthy Klamath Coalition (comprised of over 150 local Community Benefit Organizations, health providers, Klamath County Public Health, and Cascade Health Alliance (CHA)) to create an on-site food pantry for patients and their families. All families that screen as food insecure can leave the clinic with a bag of food and a gift card to the grocery store. We are looking to ramp up this program and also provide hygiene products, helmets, and car seats to families in need in 2021. Additionally, Sky Lakes hosts a weekly Produce Connection at the Sky Lakes Wellness Center located in the heart of downtown Klamath Falls. This makes inexpensive food available to community members, Sky Lakes staff, and visitors. Produce Connection is a community-wide program offered through the Lake and Klamath Counties Food Bank offering fresh produce on a weekly basis. Approximately 1.3 million pounds of food is distributed annually to 22,000 individuals, including 1,500 families, from this program. In addition, Sky Lakes hosts the Klamath Falls Farmers Market once a month in their cafeteria during the local growing season. Hosting the Klamath Falls Farmers Market at Sky Lakes connects hospital visitors, hospital staff, and community members to an additional resource to access local food.

The 2020 OHA Projects #32, #33, and #59 included aspects of the Social Determinants of Health & Equity (SDOH) component. As those projects were either modified (#32 and #33) or discontinued (#59) for 2021, CHA prioritized this new project as a singular project in 2021.

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

Klamath County is ranked the unhealthiest county in the state of Oregon. This is due, at least in part, to Klamath County's regional isolation, limited access to food, and growing poverty rates. Historically, Klamath County has had a higher rate (6.8%) of unemployed residents compared to the state average (6.6%) (December 2020). In 2015, the Oregon Department of Health and Human Services (ODHS) identified three areas within Klamath County as "high poverty hotspots" (35 -50% of residents living below the state poverty rate). Two of these designated hotspots are in the Mills Addition neighborhood. Mills Addition currently contains 15,000 of Klamath Falls' 41,000 residents, or 36.6% of the population. ODHS has ranked the neighborhood the 5th poorest neighborhood in the state of Oregon.

The 2011 Klamath and Lake Counties Food Assessment, led by the Oregon Food Bank, declared Mills Addition a food desert due to the growing poverty rates and lack of nutrition resources. People living on the border of Mills Addition have access to a handful of high-priced grocery stores like Fred Meyer and Holiday Market but have limited means for transportation and resources to pay for food. Additionally, ODHS reported in December 2020 that an average of 18,190 Klamath County residents receive benefits monthly from the Supplemental Nutrition Assistance Program (SNAP). There are about 40,000 people living within a 15-minute walking distance of Mills Addition. 24% are children and 14% of those children are considered food insecure. This is higher than the overall state average of 12%. In an event hosted at the Mills-Kiwanis Park, we surveyed families of 265 children. Of those families, 78.1% felt worried that their food would run out before they were able to buy more; and 51.6% had their food run out before they could purchase more. Having these statistics helped prove to CHA and community partners that food insecurity is an ongoing issue that last year-round.

With a focus on addressing Social Determinants of Health (SDOH) and improving economic stability, increasing access to nutritious food has not only been a priority of Cascade Health Alliance's (CHA) Community Advisory Council (CAC), but was also identified as a priority focus area in CHA's Community Health Improvement Plan (CHIP). There are currently two CAC members, who represent CHA membership, participating on CHA's CHIP food insecurity workgroup driving the implementation activities to increase food security and access to food.

As part of a strategy within the CHIP, CHA's CAC members and staff are driving implementation of a food hub in Mills Addition. CHIP priority focus areas are determined by member and community input as part of the Community Health Assessment process. Assessments are designed to collect both qualitative and quantitative data to better understand the needs and concerns of the community. This information was then used to communicate to CHA's CAC and community members through a priority focus survey to the community. The survey was distributed at a Health Fair, over social media, through email, and announced in the local paper. The survey detailed all the needs identified in the Community Health Assessment and asked community members to rank their highest concerns from top to bottom. There were 148 English surveys returned, as well as 22 Spanish surveys. The top six results were then shared with the CAC to obtain feedback and final approval.

Food hubs are a crucial part of local food systems. They connect people to food, cooking and nutrition education, all while ensuring economic growth by focusing on local and sustainably grown food. The United States Department of Agriculture (USDA) defines food hubs as "a centrally located facility with a business management structure facilitating the aggregation, storage, processing, distribution, and/or marketing of locally/regionally produced food products." Food hubs can provide the infrastructure needed for communities to develop opportunities for retailers, producers, distributers, and other businesses such as worker owned co-ops (www.healthyfoodaccess.org).

Many producers do not have time or interest in selling at farmer's markets. Farmer's markets small volume sales can be difficult on producers. Smaller producers do not have enough quantity to fill a stand. Farmer's markets have limited hours of operation. Food hubs often connect farmers/producers to new/larger markets because of the ease in logistics, single drop off and pick-up point. A food hub is bigger than a roadside stand, but smaller than the grocery/restaurant supply market – highly local. The single pick-up of many items makes it easier and healthier for customers. Location and hours are key for customers.

A food hub in Mills Addition is the community level intervention to improve food security that Klamath Falls needs.

This is a new project and no revisions were made.

E. **Brief narrative description**:

The food hub's mission to is to address the impact of hunger and food insecurity on children and families in Klamath County through strategic community-based partnerships, advocacy, and education that increase access to healthy food. Since food insecurity is an underlying factor for the economic stability domain of SDOH, this is the SDOH domain on which the food hub will focus. The food hub will be located at the Integral Youth Services (IYS) building (roughly 3,000 square feet), directly across from Mills Elementary school in Mills Addition. Operation of the food hub will be conducted by the Klamath and Lake County Food Bank and partners within the Child Hunger Coalition. The food hub will rely on partnerships with other agencies, which already provide resources to the community, and leverage their nutritional and food resources into one single on-site facility. As part of the food hub, representatives from CBO's will be available to assist community members to sign up for the Oregon Health Plan, SNAP, & WIC. The site will be open Mondays, Wednesdays, and Thursdays for the general public to come in, access food, and get on-site resource support. Tuesdays and Thursdays will be reserved for CBOs to hold sessions such as cooking classes, neighbor support meetings, and more. Community partners and healthcare system representatives include: Integral Youth Services, Klamath and Lake County Food bank, Department of Human Services, Sky Lakes Medical Center, Klamath County and Klamath Falls City Schools, both City and County Local Governments, Oregon State University Extension Office, Klamath Promise, and more. The food hub and its offered activities will allow CHA to directly test its impact to improve hunger rates and access to nutritional food within a high poverty area.

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

Activity 1 description (continue repeating until all activities included): Improve food security for families and children within Mills Addition through the implementation of a food hub.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Formalize partnerships through memorandum of understanding (MOU) agreements and recruit and retain food retail vendors.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current formal agreements to operate the food hub	Enter in formal MOU agreements with participating partners	06/2021	100% of partners have formal MOUs to operate the food hub	09/2021
Only vendor is the food bank	More than one food vender will participate in the food hub	9/30/2021	At least 10 vendors will participate in the food hub	3/2022

No food hub in Mills Addition	Establish food hub.	9/2021	Food hub open three days a week to general public	3/2022

Activity 2 description: Increase food and nutrition educational opportunities.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: CBOs offer cooking classes at the food hub in Mills Addition regularly.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No cooking classes available at the food hub.	Implement cooking class schedule and assign dates to CBOs.	1/2022 TBD COVID-19 Pending	Cooking classes offered regularly (frequency TBD COVID-19 pending)	7/2022 TBD COVID-19 pending

A. Project short title: Medical Dental Integration

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

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

B. Components addressed

a. Component 1: Oral health integration
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

The previous Oral Health Integration Project (OHA Project #60) focused on Care Coordination for Vulnerable and At-Risk Populations, specifically members with diabetes who have comorbid chronic or complex conditions, and members that are pregnant. The main objectives of that project having been met, the work is now being sustained through the Klamath Basin Oral Health Coalition and sustained CHA processes and workflows. Therefore, Cascade Health Alliance has chosen to reallocate its resources to a new medical/dental integration project. Details outlining closure of the previous project are noted below in Section 2.

Please see the attached oral health brochures. These were work product from the previous Oral Health Integration project (OHA Project #60).

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

The Oregon Health Authority identified three high risk co-morbidities amongst the Oregon Health Plan membership: Hypertension, Diabetes, and Tobacco. With the recent formation of a Medical-Dental Integration Partnership by the

Center for Disease Control's Division of Oral Health, there is momentum among the healthcare community to broaden screening capabilities for patients with chronic diseases.

Currently, Klamath Health Partnership dba Klamath Open Door (FQHC Federally Qualified Health Center) is a fully integrated clinic offering physical, oral, and behavioral health services at one location. For patients with greater behavioral health needs, Klamath Health Partnership has a primary care provider co-located at Klamath Basin Behavioral Health (CMHP) who can assess oral health needs and refer patients to Klamath Open Door's main clinic for treatment if needed.

Within our local healthcare system, the use of multiple, different electronic health records among the provider network, as well as lack of use of the available Health Information Exchange, Reliance eHealth, has created a challenge to full integration of the healthcare system, particularly among the dental community. While the network's dental providers utilize CHA's web-based portal for authorization submittal, only one oral health provider is currently utilizing Reliance (Klamath Health Partnership dba Klamath Open Door (FQHC Federally Qualified Health Center)) for purposes of data sharing through the Community Health Record, with no dental providers utilizing Reliance eHealth to send referrals to members' primary care providers. The lack of dental providers utilizing Reliance eHealth also makes primary care submittal of referrals to dental providers less efficient. This deficiency presents an opportunity to improve services provided to our members and further move the healthcare system toward integration of services across provider types.

Dental providers in CHA's network are located within the city of Klamath Falls, making transportation for those living in outlying areas a potential limitation and concern. "Free Dental Days" are typically held one time per year in the outlying areas of Merrill and Malin and are staffed by [redacted] who provides screenings and preventive services to primarily children through a contract with CHA) and other local providers through equipment provided by OHA. Free Dental Days serve an average of 60 members of the community (including CHA members). Clinics were unable to be held during 2020 due to COVID-19 closures and limited provider availability once dental offices were permitted to resume treating patients. While these clinics offer treatment to those who would otherwise not be able to easily access oral health care, it still requires the patient to travel to commercial hub for services. This limits the availability of oral healthcare for individuals living in remote, frontier areas of Klamath County.

Acquisition of a mobile dental van would allow for dental treatment in a non-traditional setting, provide oral health care to members services to who live in remote regions of Klamath County, and increase the provision of necessary screenings or tobacco use, diabetes, and hypertension with accompanying referrals for high-risk members.

E. Brief narrative description:

CHA will partner with local oral health providers within its network to fully implement Reliance eHealth for purposes of data sharing between all participating provider types and referrals based on screening outcomes. CHA will begin this work through partnership with a local teaching institution, the Oregon Institute of Technology (OIT) to bolster the number of disease (Hypertension, Diabetes, and Tobacco) screenings completed by Dental Professionals. OIT has a CODA accredited Dental Hygiene Program located in Klamath Falls, Oregon, that trains approximately 40 candidates/year.

CHA has an existing partnership with OIT, as its members obtain much needed dental services at their location. Additionally, the [redacted]) is a Hygiene instructor in OIT's Dental Hygiene program. Dental Hygiene candidates will medically screen patients, and then when appropriate, utilize Reliance eHealth to facilitate a referral to the member's primary care home for further treatment. Currently, the students see an estimated 1 patient/assigned clinical block. Their thorough medical history intake makes for a smooth integration of the screening process into their already existing workflow. This slower paced schedule will allow the students to properly engage patients while assessing their medical health risks, and those who are high risk will be referred accordingly. Both

students and members will benefit from the enhanced medical knowledge by mitigating the challenges OIT experiences in waiting for returned medical clearance forms, thereby expediting the administration of dental treatment.

CHA will actively pursue funding for the purchase of a mobile dental van and implementation of services in partnership with an existing dental provider. The van will include technological capabilities to allow for remote EHR and Reliance access for charting of services provided and moment-in-time referral of high-risk members based on screening outcomes.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Dental providers integrated into HIE (Reliance eHealth)

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Onboard dental providers to the Reliance eHealth platform

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 oral health provider currently utilizing Reliance eHealth	50% of network oral health clinics utilizing Reliance eHealth to its full capacity	1/2022	100% of network oral health providers in CHA's network utilizing Reliance eHealth to its full capacity.	1/2023
OIT not currently utilizing Reliance eHealth	Establish relationship between OIT and Reliance eHealth	4/2021	Contract executed between Reliance eHealth and OIT	6/2021

Activity 2 description: Implementation of workflow for preventive screenings and referral via Reliance eHealth at Oregon Institute of Technology.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Template created, workflow revised, staff trained in its use; students trained in workflow, use of Reliance eHealth, platform and new workflow utilized and process sustained over time.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Template for screenings not created	Template created for screenings and process added to current workflow	9/2021	Templated integrated into current electronic health/dental record	12/2021
Staff using old medical history and screening workflow	Staff trained in revised medical history and screening workflow	12/2021	Staff utilizing new medical history and screening workflow	1/2022

4th year Hygiene Students using old medical history and screening workflow	50% of 4th year Hygiene Students trained in revised medical history and screening workflow	1/2022	All 4th year Hygiene Students utilizing new medical history and screening workflow	12/2022
3rd year Hygiene Students using old medical history and screening workflow	50% of 3rd year Hygiene Students trained in revised medical history and screening workflow	1/2023	All Hygiene Students utilizing new medical history and screening workflow; process fully implemented	12/2023
Medical history, screening, and referral not completed electronically	Medical history, screening, and referral of 50% of OIT assigned CHA membership 18 years and older conducted electronically via Reliance eHealth	6/2022	Medical history, screening, and referral of 100% of OIT assigned CHA membership 18 years and older conducted electronically via Reliance eHealth	1/2023

Activity 3 description: Acquire and deploy Mobile Dental Van

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: CHA members screened and referred as appropriate.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No funding for mobile dental van	Research funding opportunities and apply for grant(s)	12/2021	Funding for acquisition of mobile dental van secured	6/2022
Mobile dental van not purchased	Mobile dental van purchased	4/2023	Same as Target	Same as Target
Mobile dental not in use	Mobile dental van utilized on regular scheduled cadence to reach members living in remote areas	9/2023	Same as Target	Same as Target

A. Project short title: Member Reassignment

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

If continued, insert unique project ID from OHA: 61

B. Components addressed

a. Component 1: Grievance and appeal system
b. Component 2 (if applicable): Health equity: Data

c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

In 2020, the Appeals and Grievances domain was the primary component in the Member Reassignment project (continuation of a project begun in 2018, continued into 2019). During 2020, CHA added member reassignment requests to the data collection and reporting structure for tracking grievances and appeals. Reporting structure now includes this information in quarterly grievance and appeals dashboards. The secondary activity focused on provider education and expectations for reporting to CHA when providers dismissed members from their practice, as this information was submitted to CHA on an inconsistent basis and not in a standard format, making aggregation of provider data challenging. An informal system is in place to capture member reassignment due to member dismissal by a provider, however the establishment of a formal tracking system remains as part of this project.

The Public Health Emergency delayed provider training until late in the 2020 calendar year as both provider and CHA attention was focused on our community COVID-19 response. The Dismissal of Care template was created and expectations for its use included in the November 2020 provider training via a virtual platform. Because only 16.2% of CHA's active network providers to date participated in the training and attested to receipt of the information regarding member reassignment, grievances and appeals, and reporting requirements, provider training remains as a monitoring activity for 2021. Consistency of provider reporting of member dismissal continues to be validated.

Items from the previous project that were derailed due to COVID-19 remain as deliverables this year.

In 2020, the domain of Health Equity: Data was the primary component in the Improve/Increase Data Collection and Analysis Capacity to Inform Member Needs project (OHA Project #32). CHA developed systems to improve SDOH data collection to better serve members. CHA completed full implementation of Aunt Bertha (Community Information Exchange (CIE)) in 2020 dba Healthy Klamath Connect (HKC) in partnership with The Healthy Klamath Coalition. The Healthy Klamath Coalition, a partnership between CHA, Sky Lakes Medical Center, and Blue Zones led to the City of Klamath Falls achieving the first certified Blue Zones community in the Pacific North West in February 2021. This branded CIE community site, Healthy Klamath Connect (HKC), provides local community services options for all community members (including CHA members) addressing SDOH needs. There are over 100 local community-based organizations offering services in Klamath County in the online platform as of February 2021, with goods and services ranging from clothing, medical supplies, and food to housing advice, temporary shelter, and transit services. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH in HKC and [redacted] (CHA's Case Management platform). CHA also implemented a digital version of the PRAPARE social needs assessment and included it in our current [redacted] 3 version for all internal [redacted] users to capture additional SDOH data. CHA is also continuing participation with our local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative. Reliance has expanded its SDOH reporting to include housing and food insecurities that includes Natural Language Processing (NLP) to assist in identification of participating providers and CHA shared clinical data. In early 2020, CHA completed integration of an Application Program Interface (API) connection with Reliance sharing all its 837 claim data files. CHA focused on systems development and data collection and validation with the creation of equity and metrics performance dashboards stratified by SDOH data still in process.

Please see the following documents as supporting documentation:

- Healthy Klamath Connect

- 2020 Grievances, Appeals, and Denials reports
- Appeals/Grievances 2020 Provider Training (which includes training on Member Reassignment expectations of providers)

Activity #2 from OHA Project #32 is noted as successfully closed (please see below in Section 2), while Activity #1 continues with this project.

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

Member experience with the healthcare system affects health outcomes in that individuals are more capable of improving their health when they understand how to do so and are active participants in their care plan. Despite the efforts of the local healthcare system to improve care, members do not currently rate the local healthcare system highly. CHA Adult CAHPS data show the Rating of Health Care (63.3%) and Rating of Health Plan (61.89%) as lower than most individual items surveyed. Both ratings are lower than the State average (71.87% and 71.28%, respectively). Similar themes are present across Cascade Comprehensive Care's (CCC) Medicare Advantage (MA) plan CAHPS data.

CHA utilizes multiple sources of member experience data and reporting methods: OHA, Healthy Klamath, County Health Rankings, Healthy Klamath Connect, CHA's Community Advisory Council, Delivery Service Network (DSN) Narrative and Capacity Report, PCPCH enrollment, service utilization and claims, Language Line utilization, and grievances and appeals data. The majority of grievance and appeal data comes from internal sources; however, TransLink via Sky Lakes Medical Center and [redacted] are external sources providing additional data. However, due to the broad nature of member experience data and its many sources, current data related to member experience is scattered amongst multiple reports, at times is outdated by the time it is reported, not member or topic specific, and, in some cases, not easily accessible by CHA. These challenges provide an improvement opportunity to better identify and remediate the root causes of low satisfaction ratings by members. Improvement opportunities include more in-depth data analysis, aggregation of data from multiple sources, collection of additional data points when gaps are identified, and conversion of data into actionable information for use both internally and by the provider network.

Grievances and appeals data provide another source of information to assess member satisfaction with the local healthcare system. CHA has policies and procedures in place for appeals, notice of action, hearing, and grievances. In 2020, processing of grievances and appeals transferred from the Compliance department to the Member Services department to further increase CHA's dedication to member experience. However, the Compliance Committee (a Board of Directors sponsored Committee) continues to have ultimate oversight over member grievances and appeals, including quarterly monitoring of all data and corrective action plans.

Member grievances and concerns specific to individual providers/clinics and/or provider subgroups are reviewed monthly by the Provider Network Committee (composed of representatives from the following internal CHA departments: Operations, Provider Network, Quality, Case Management, Member Services, and Business Intelligence/Decision Support). Concerns raised during regular monitoring of subcontractors and/or delegated entities either through the annual audit process or regular data submission are also brought to the Provider Network Committee for review and action if necessary. In 2020, the highest number of grievances were related to Access to Care (43%) followed by Interactions with Providers or Plan (30%). It should be noted that, in 2019, the highest number of grievances were Interactions with Provider or Plan. Further data analysis will determine if the Public Health Emergency was a contributing factor regarding members' perceived Access to Care in 2020. Additionally, improvements were instituted in 2020 and continue in 2021 to ensure interrater reliability on the capture of grievance categories for more accurate reporting.

Hearings occur less frequently due to a rule change in January 2019 whereby members cannot schedule a hearing at the time they file an appeal. However, the number of hearings increased in 2020 when the time allotted to schedule a hearing was extended due to COVID-19. Specialty care (45%), dental (19%), and pharmacy (12%) accounted for the majority of appeals while pharmacy (54%) and specialty care (17%) account for the majority of denials. Overall, the majority of the appeals and denials were related to non-covered services as well as services that are not considered medically appropriate. This demonstrates an educational opportunity for both members and providers which will be addressed in the Comprehensive Utilization Plan and NEMT project.

CHA can better support providers to improve their interactions with members, including the provision of culturally and linguistically appropriate services, by taking a new approach to evaluating grievance and appeals data. During a recent gap analysis, one significant data gap identified is the lack of grievances and appeals data stratified by race, ethnicity, language, and disability status. Concurrently, member reassignment data is also not stratified by race, ethnicity, language, or disability as it is included with aggregate grievance and appeal reporting. Race, ethnicity, language, disability, and unmet social needs can affect member experience and health outcomes. If healthcare and community services are not equitable, historically vulnerable populations may be further disadvantaged and will continue to lack the opportunity to reach their full health potential and well-being. For example, the Agency for Healthcare Research and Quality (AHRQ) demonstrated in their 2019 National Healthcare Quality and Disparities Report that "Hispanics received worse care than Whites for more than one-third of quality measures" from 2000 through 2016-2018. Collection of this data, including its analysis, may provide further insight into why members file a complaint (grievance), as well as identify additional opportunities for CHA to better serve members and improve health outcomes. Of 21,498 members, 37%, or 7,790 members, have not disclosed their race; 52% (11,103) have not disclosed their ethnicity of 11,103 members; and 18% (3,939) have not disclosed their preferred language. Once identified and evaluated, CHA will partner with its provider network to ensure the provision of culturally and linguistically appropriate services to members by identifying areas of opportunity, gaps in services and community resources, and correct consistent areas of member complaints.

Strengthening CHA's data collection and reporting structures, including more robust data analysis to include race, ethnicity, language, and disability will allow CHA to better connect members to community resources through Healthy Klamath Connect (Community Information Exchange) and provider generated distribution of resources and improve member experience with our local healthcare system.

E. Brief narrative description:

CHA will stratify grievances and appeals data by race, ethnicity, language, disability, and social determinants of health status to create targeted and tailored member outreach, communication, education, and quality improvement opportunities. This process will include updates to infrastructure (policies and procedures, and data capture, collection, reporting, and analysis) and build upon the partnerships CHA has developed with providers, clinics, community-based organizations, and other community partners. CHA will utilize data from currently available sources, including [redacted] and TransLink, as well as continue to invest in additional collection methods. In addition to supporting this project, improved data collection will support other CHA TQS projects, including the Cultural and Linguistic Services Provision project. This project is transformative because efforts will eliminate health disparities and increase culturally and linguistically responsive services within the health system, so all community members have the opportunity to reach their full health potential and well-being.

In 2021, CHA will implement a new platform from [redacted] version 4.2 with enhanced member data and REALD and SDOH capturing capabilities. CHA will continue participation with our local southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative, and include the enhanced data captured in the new [redacted] platform. Reliance has expanded their REALD and SDOH reporting to include housing and food insecurities that includes Natural Language Processing (NLP) to assist in identification of participating providers and CHA shared clinical data. CHA intends to collaborate on additional REALD and SDOH reporting capabilities with Reliance

to consolidate CHA and participating provider data captured. CHA can utilize this additional data to assist in care plans and identification for additional interventions.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Establishing a Notification of Member Dismissal and Reassignment policy and process to be more culturally responsive to member needs by being immediately responsive to member dismissal and reassignment.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Document policies, procedures, and workflows for Member Dismissal and Reassignment.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No written policy for Notification of Member Dismissal and Reassignment	Policy created to include provider responsibility of notifying CHA of member dismissal, including timelines established for notification and member reassignment	05/2021	Process implemented and sustained	10/2021
No internal written workflow for processing member reassignments due to provider dismissal	Create written workflow for processing member reassignment per Provider Dismissal Advisement	05/2021	Workflow documented and in consistent and sustained use.	10/2021
No written workflow for capturing clinics open and closed to new assignments.	Document process for documenting open and closed clinics.	6/2021	Disseminate written process to any applicable internal and external partners and stakeholders.	7/2021
Few (16.2% 11/2020) Providers trained in Dismissal of Care template and requirements for reporting	50% of Providers trained in Dismissal of Care template and requirements for reporting	7/2021	100% of Providers trained in Dismissal of Care template and requirements for reporting	12/2021

Activity 2 description: Utilize current and new systems to improve the capture of REALD and SDOH data to increase transparency of member needs with outreach, care coordination, and planning interventions.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Continue making progress collecting REALD and SDOH data while implementing system updates.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
[redacted] case management platform with limited reporting capabilities	Implement [redacted] with improved reporting capabilities	5/2021	Implement [redacted] and Customer Relations Management (CRM) tool interoperability	08/2021
No CRM tool	Implement CRM Tool	CRM Tool: 06/2021	Utilize CRM campaigns and [redacted] and CRM interoperability for transparency of member needs (Including health equity needs) with outreach, care coordination, and planning interventions	03/2022
10% of Member Self-Reported REALD and Social Determinant of Health Data currently captured	Capture 20% of Member Self-Reported REALD and Social Determinant of Health Data.	06/2022	Capture 40% of Member Self-Reported REALD and Social Determinant of Health Data.	12/2023
Equity (Member Demographics) dashboard is disseminated to select staff and contains race, ethnicity, and language.	Equity dashboard is disseminated regularly to all applicable internal and external partners and stakeholders.	12/2021	Update equity dashboard to include disability status.	12/2022
(Modified Activity #1 OHA Project #32) Fragmented data collection and no stratified reports	Stratify all quality reports by REALD (i.e., access, utilization, incentive metrics, and improvement project outcome measures).	3/2022	Utilize REALD data to inform member outreach, engagement, and education programs and strategic plans to eliminate health disparities.	Same as target

Activity 3 description: Stratify grievances and appeals data (including member reassignments) by REALD.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Update Grievance and Appeals process to create grievance and report stratified by REALD.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

No Grievance and Appeals Policy/Procedure integrated with REALD System Policy and Procedure.	Amend the existing or create a Grievance and Appeals Policy/Procedure to integrate REALD System Policy and Procedure.	06/2021	The new process is implemented.	09/2021
No grievance and appeals report stratified by REALD.	Creation of Grievance and Appeals Report stratified by REALD	09/2021	Monthly Grievance and Appeals Reporting stratified by REALD	01/2022
0% of Grievance and Appeals reports stratified by REALD	100% of Grievance and Appeals Reports stratified by REALD	12/2023	Utilize report for planning interventions based on documented gaps.	12/2024
2 subcontractors provide Grievance and Appeal data	Add Grievance and Appeals data from 1 subdelegate or subcontractor (for a total 3)	12/2022	Add Grievance and Appeals data from 2 additional subdelegates or subcontractors (for a total of 5)	12/2023

A. Project short title: Comprehensive PCPCH Plan

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

If continued, insert unique project ID from OHA: CHA Project #6: Value-Based Payment (VBP) Models and Methodology PCPCH was not given an OHA project ID in 2020 due to feedback from OHA and a request to submit a revision for VBP's subcomponent Access: Cultural Considerations (OHA Project ID #62)

B. Components addressed

a. Component 1: PCPCH: Tier advancement
b. Component 2 (if applicable): PCPCH: Member enrollment
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

Due to the substantial number of enrolled members assigned to PCPCHs (97%), CHA's previous PCPCH efforts focused on value-based payments to drive provider achievement of the targets on OHA's incentive metrics. CHA has a robust metric data collection and visualization system for reporting provider metric performance, and consistently participates in technical assistance and study opportunities offered by OHA and ORPRN as they relate to our strategic objectives and metrics performance improvement. However, CHA has historically not actively assisted providers in advancing their PCPCH tier level.

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

Patient-Centered Primary Care Homes (PCPCH) are instrumental in improving health outcomes, lowering the cost of healthcare, and improving patient and provider experience (quadruple aim) through their ability to offer multiple services. With PCPCH recognition, a primary care clinic is more likely to provide care that is accessible, accountable, comprehensive, continuous, coordinated, and patient and family centered. The primary care clinic has a higher degree of accountability to maintain standards to satisfy these core PCPCH attributes, so the clinic can retain PCPCH recognition or increase its PCPCH tier level. A clinic will have to provide a higher level of care and meet more standards to achieve a higher tier level. A 2016 OHA study found a clinic can save $28 per member, per month after three years of having a PCPCH designation while also reducing utilization rates for specialty office visits, radiology, and the emergency department. Oregon has more than 600 PCPCHs providing access to over a million Oregonians. Of 21,471 CHA members with physical health coverage, 97% (20,911 members) are assigned to a PCPCH clinic. When taking into account tier level, CHA's PCPCH weighted score is 79% when 1 primary care clinic is 5 Star, 2 primary care clinics are 4 Star, 2 primary care clinics are 3 Star, and 3 primary care clinics are not PCPCH. These numbers are based on November 2020 member enrollment data. As of 2019, 96% of Oregon CCO members were enrolled in a PCPCH, resulting in a weighted score statewide of 79%.

To date, there has been no coordinated effort across the local healthcare system directly focused in PCPCH tier advancement. Individual clinics have worked independently to implement the necessary policies and processes to maintain their status or advance. Per American Medical Group Association (AMGA), learning collaboratives use shared learning to accelerate systemic change and improve organizational performance and the quality of patient care and experience. Learning collaboratives also encourage team building while technical assistance (TA) provides an opportunity to meet providers "where they are" with tailored assistance according to the Center for Health Care Strategies, Inc (CHCS). Learning collaboratives and TA should be designed to support meaningful participation and clinic ownership of the transformation process to increase buy in. CHA has built close relationships within its provider network. A learning collaborative would enhance these relationships by increasing CHA's understanding of clinic strengths and challenges and create a venue for the sharing of best practices across the healthcare system. Including Community Benefit Organizations and other community stakeholders would further increase alignment of initiatives across our community to improve health outcomes.

E. Brief narrative description:

CHA will take a more active role in tier advancement of its network PCPCH clinics through the development of a comprehensive PCPCH plan for tier advancement and member enrollment. Instead of focusing efforts on simply increasing member assignments to PCPCH clinics, CHA's goal is to increase member enrollment in higher tiered PCPCH clinics because CHA's percentage of members enrolled in a PCPCH clinic is high and higher tier recognition implies a high quality of care. The plan will include updating our internal infrastructure to manage member assignment in PCPCH clinics, improving interdepartmental and interorganizational collaboration and alignment, and increasing member awareness of the benefits of belonging to a PCPCH for improving patient care and health outcomes. Through this process, CHA will prioritize PCPCH clinics when assigning new members and unassigned members to a primary care provider.

Efforts will include the establishment of a PCPCH learning collaborative for purposes of technical assistance (TA) and the sharing of best practices to support local PCPCH's to advance to a higher tier level as well as to deepen the network's understanding of member experience. TA will be designed to aid clinics that may need extra assistance or help overcoming barriers to meeting certain PCPCH standards. Using the PCPCH standards as a guide, topics will be prioritized by those that align with other CHA initiatives as well as identified areas for improvement. The project will target current PCPCH clinics while encouraging the participation of other network providers (non-PCPCH primary care, specialty,

behavioral health, and oral health providers). Member education materials will be created focusing on the benefits members can expect from their assignment to a PCPCH clinics.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Using the PCPCH comprehensive plan, provide local TA and opportunities to share best practices for PCPCH clinics.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Development and implementation of PCPCH comprehensive plan and learning collaborative.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No PCPCH comprehensive plan.	PCPCH comprehensive plan developed.	3/2021	PCPCH comprehensive plan implemented and established.	6/2021
No PCPCH comprehensive learning collaborative.	PCPCH learning collaborative developed.	6/2021	PCPCH learning collaborative implemented and established.	8/2021
0% of PCPCH clinics participate in learning collaborative.	50% of PCPCH clinics participate in learning collaborative.	6/2021	100% of PCPCH clinics participate in learning collaborative.	12/2021

Activity 2 description: PCPCH member education

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Development and use of member education materials related to the benefits of belonging to a PCPCH.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
New member packets do not include benefits of belonging to a PCPCH.	Create PCPCH pamphlet.	07/2021	100% of new members are sent pamphlet in new member packets.	12/2021
CHA's website does not include information on the benefits of	PCPCH information is added to the website.	06/2021	75% of members not assigned to a PCPCH clinic receive text with link to PCPCH information on website.	8/2021

belonging to a PCPCH.				

Activity 3 description: Increase member enrollment in higher tiered PCPCH clinics while prioritizing PCPCH clinics when assigning new members and unassigned members to primary care provider.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Monitor CHA's PCPCH weighted score.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
79% (weighted score; 20% of PCPCH clinics are 5 Star, 40% of PCPCH clinics are 4 Star, 40% of PCPCH Clinics are 3 Star)	85% (weighted score; 20% of PCPCH clinics are 5 Star, 80% of PCPCH clinics are 4 Star)	3/2022	95% (weighted score; 60% of PCPCH clinics are 5 Star, 40% of PCPCH clinics are 4 Star)	6/2023

Project short title: Cultural and Linguistic Services Provision

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

If continued, insert unique project ID from OHA: 32, 33

A. Components addressed

a. Component 1: CLAS standards
b. Component 2 (if applicable): Access: Cultural considerations
c. Component 3 (if applicable): Health equity: Cultural responsiveness
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? 13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

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

This narrative reflects prior year assessment of OHA Project #32 and #33 as multiple activities were completed, and those remaining combined into one continued project to complete the work, with the addition of new activities.

In 2019, a Health Equity Assessment was completed through 3 focus groups: internal CHA staff, providers within our network, and the Community Advisory Council. Information was gathered through a series of 10 questions to gauge the level of cultural competence among the three groups and the community at large. The assessment identified varying degrees of internal challenges with misperceptions and staff attitudes towards members. Some of the gaps identified in the health equity assessment were remedied in 2020 through a five-session training for CHA staff on trauma-informed

care, Adverse Childhood Experiences (ACEs), recovery principles, and motivational interviewing. The first session was offered in-person in February 2020, but due to COVID-19 the remaining four sessions were provided virtually through RingCentral Meetings finishing in September 2020. Overall, there was a 99% attendance rate for the series with sixty-two (62) of sixty-six (66) total staff completed the training (four staff members were excused due to personal trauma histories). Additional training opportunities identified through the assessment and subsequent work in preparing the CHA's Health Equity Plan are planned in the future.

CHA has met the 2020 TQS goal for this project and successfully translated 100% (up from 80%) of all required member materials into Spanish. Additionally, the member handbook is available in audio and large print formats. All other materials are available in large print upon request as they can be produced in-house at a moment's notice. Most member materials are not immediately available in audio format but are provided within 48 hours of the request.

The Community Information Exchange (Aunt Bertha), branded as Healthy Klamath Connect, was fully implemented in August 2020. At this writing, active participants include 172 Community Benefit Organizations, Klamath County Public Health, 2 major clinics (Klamath Health Partnership (FQHC Federally Qualified Health Center), Sky Lakes Outpatient Care Management), and two Behavioral Health providers, Lutheran Community Services and Klamath Basin Behavioral Health (CMHP). Recruitment continues to bring more independent clinics/providers and provider types on board. Please see the attached document, Healthy Klamath Connect.

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

CHA's members are diverse in their cultural backgrounds and language preferences. Analysis of 2020 demographic data shows that 78.1% of CHA members prefer English (16,788 members), with the remaining 21.9% either not reporting a preferred language or indicating that they prefer Spanish, Chinese, or another language. With only 3.4% identifying they speak Spanish (731 members) and 0.1% speaking Chinese or another language (30 members) of the 21.9%, there is a gap of 18.9% of members that did not report their spoken language. There is the potential for a sizable number of members who need language assistance but have not declared so. Additionally, the World Population Review estimates that 7.02% of Klamath County residents speak Spanish as their first language, which is not reflected in the 3.4% who identify as speaking Spanish within CHA's data. According to the American Community Survey for Klamath County, more individuals are being identified as needing language assistance due to limited English proficiency (LEP), deafness, or hard of hearing. Since 2013, linguistic isolation has been slowly increasing with more people self-identifying as having difficulty speaking English. As seen in the member demographic data below, over the last three (3) years CHA's overall membership has increased and non-English speaking members has not increased proportionally thus the percentage decreased. CHA continues to monitor and address the growing cultural and linguistic needs of its members and strives to go beyond OHA's expectations for providing language assistance (when 5% of members declare the need) to ensure that all members have equal access to information even if they did not formally declare a need for language assistance. Through demographic data analysis, identified gaps will be addressed through this project.

Eligibility

	CY2018
Row Labels	**Count of DMAPID**
Afghan, Pashto, Pashtu	1
Arabic	4
Cantonese, Mandarin, Other Chinese/Asian, TaoChiew	18
Central American Indian, ElSalvadorian, Guatemalan	2
Dutch	2
English	17760

Gujarati	3
Laotian	2
Other, Undetermined	221
Spanish	749
Swedish	1
Vietnamese	5
Grand Total	**18768**

18768-17760=1008 1008/18768= 5.4%

Eligibility

CY2019

Language	Count of DMAPID
(blank)	11
Afghan, Pashto, Pashtu	1
Arabic	1
Cantonese, Mandarin, Other Chinese/Asian, TaoChiew	17
Central American Indian, ElSalvadorian, Guatemalan	2
Dutch	2
English	18700
Gujarati	3
Hearing Loss, Sign Languages	1
Hmong, Mong, Mien	2
Other, Undetermined	166
Spanish	779
Swedish	1
Vietnamese	5
Grand Total	**19691**

19691-18700=991 991/19691=5.03%

Eligibility

Sept. 2020

Language	Count of DMAPID
(blank)	51
Arabic	2
Cantonese, Mandarin, Other Chinese/Asian, TaoChiew	17
Central American Indian, ElSalvadorian, Guatemalan	2
English	20189
Gujarati	3
Hearing Loss, Sign Languages	2
Hmong, Mong, Mien	2
Laotian	3
Other, Undetermined	147
Spanish	795
Swedish	1

Vietnamese	6
Grand Total	**21220**
21220-20189=1031	1031/21220= 4.9%

Spanish-speaking patients report feeling more comfortable with bilingual providers than with translators or interpreters. Additionally, bilingual staff members are more effective at reducing no-show rates, unplanned hospitalizations, and average length of stay than interpreters alone. In the absence of bilingual providers or staff, as stated earlier, CHA provides access to a language line for member and provider use. CHA's ability to report on the utilization of this service is severely limited by a third-party vendor who cannot provide member-level data. Additionally, not all CHA providers use the same third-party language access line, which further limits our ability to collect, aggregate, and analyze language access data, and there is no systematic way to collect, aggregate and analyze data on the number of services provided by bilingual providers or their staff. The planned Meaningful Language Access activity will improve CHA's ability to collect and aggregate data. The improved data process will enable CHA to accurately analyze member-level language access utilization data to guide the future identification of gaps, improvement opportunities, and solutions.

CHA is seeking the NCQA Multicultural Healthcare Distinction to be a leader in CLAS standards in our community to ensure that all members have access to equitable care and services that are culturally and linguistically appropriate. The certification process will involve our provider network and community partners to ensure that not only our members, but the entire community has access to culturally and linguistically appropriate care and services. By achieving CLAS Standards throughout the CHA service area and Klamath County, we will help to eliminate health care disparities, ensure marginalized and vulnerable populations receive the care they need, improve member experience and satisfaction, improve quality of care and services, advance health equity, and improve health outcomes for individuals in our community.

New member materials will continue to be translated into Spanish as they roll out, and CHA will increase the percentage of member materials available in large print and audio formats. To improve access to culturally and linguistically appropriate member materials and promote health equity, the MLA (Meaningful Language Access) activity strives to increase the number of member materials available in these alternative formats and continues with work begun under the previous TQS OHA Project #33.

CHA currently has two bilingual staff employed. Using spoken language as a proxy for cultural diversity, although CHA's staff is diverse, it does not mirror the enrolled membership. This presents CHA with an opportunity to seek out and recruit employees that speak additional languages to ensure that our services are culturally responsive to member needs and help transform the way that care is delivered.

D. Brief narrative description:

The Cultural and Linguistic Services Provision (CLSP) project addresses three TQS components: CLAS Standards, Access: Cultural Considerations, and Health Equity: Cultural Responsiveness. This is a multi-year project aiming to achieve several CLAS standards through internal activities as well as activities with our provider and community partners. While improving infrastructure, CHA will ensure members have the opportunity to participate in choosing services that are delivered in an appropriate setting and meet their unique needs. The primary CLAS standard addressed in this project is standard #13: Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness. Activities will be supplemental to several focus areas outlined in CHA's Health Equity plan including the focus area to obtain the NCQA Multicultural Healthcare distinction by completing a readiness review, gap analysis, and an implementation plan using the NCQA guidelines as a gold standard while also reviewing and taking into consideration Oregon state and federal laws about accessibility and communication. The activities for the CLAS standards portion of this TQS project will primarily focus on working with our provider and community partners

and completing the same activities with them that are being completed internally at CHA through the Health Equity Plan.

The Meaningful Language Access (MLA) activity enables CHA to deliver culturally and linguistically appropriate services for members. This activity has three components designed to achieve this goal: (1) monitor members' language access line utilization, (2) translate member materials (continuation of OHA Project #33), and (3) train staff to improve cultural competence. Currently, the third-party vendor responsible for delivering language access services for CHA members and its provider network is limited in its ability to report accurate member level utilization data. CHA is actively seeking a contract with a new language line vendor with expanded data reporting capabilities. Once the contract has been executed, we will develop and implement a language access reporting process to ensure this limitation is remediated. After successful implementation of a language access reporting process, CHA will have access to more accurate and meaningful data that will allow us to monitor how members and providers utilize the language access line, identify remaining gaps in services, and other improvement opportunities to improve access to culturally and linguistically appropriate services for members. The second component of the MLA activity is translating member materials (continuation of OHA Project #33). Translating member materials into accessible languages and formats for CHA's diverse members allows us to decrease miscommunications and improve member experience. The MLA activities will prioritize which translated materials need to be readily available based on our member and community demographic data and which materials can be provided upon member request. CHA currently contracts with an outside entity to provide all outgoing member materials in alternative languages within 24 hours to ensure that updated materials are available within 48 hours to members as they request them in languages other than English. Additionally, CHA will provide alternative formats (such as large print, provided by Koko Graphics, and audio, provided by Wynn Broadcasting) to members upon request within 72 hours.

The Workforce Development activity lays the groundwork for CHA to better promote organization-wide cultural competence by increasing the number of bilingual staff, increasing the number of staff focused on health equity work, and ensuring that existing staff members are trained to recognize implicit biases and improve their cultural responsiveness. As CHA's limited English proficiency (LEP) members are estimated to be anywhere from 3% to 22% of total membership (as noted above), the Workforce Development activity intends to hire an additional four (4) bilingual staff for a total of six (6). In addition to recruiting more bilingual staff, CHA will build a formal health equity department, led by its current Director of Member Services and Health Equity, by recruiting several staff who specialize in health equity as follows to lead CHA's transformation into a more culturally competent organization and better serve its diverse membership:

Health Equity Manager to manage daily health equity activities, examine current internal practices and make recommendations for improvement

Health Equity Coordinator to work directly with members, including connecting CHA members to community and social support services as well as statewide resources as needed.

CLAS Coordinator to ensure that the transformation is in alignment with and supportive of CLAS standards.

The final component of this project is continued training of CHA staff to improve their level of cultural competence, recognize implicit biases and improve their cultural responsiveness to promote health equity. CHA will deepen its Cultural Competence Training Plan based on recommendations received during the development of the Health Equity Plan. Additionally, staff training sessions will regularly ensure all staff members are aware of language assistance services available to members and how to access them. Training sessions will be held annually and information from the trainings will be incorporated into the staff handbook. Cultural competence training improves the attitudes, knowledge, and skills of our staff working with the diverse populations in our service area. Ensuring case managers and member services staff have skills in cultural competence and those skills are refreshed every year will help to address systemic

inequities as well as improve the care coordination and health care system navigation that members receive in addition to referrals to resources and services that support social and emotional health. Regular and consistent staff training in conjunction with the recruitment of health equity and bilingual staff will lead to improved patient satisfaction, improved quality of care and service provided to members, and promote health equity throughout our organization and community.

The CLSP project in conjunction with the Health Equity plan will improve CLAS standard achievement community-wide to ensure that members receive culturally and linguistically appropriate care and services at CHA, within our provider network, and across community organizations. CHA will achieve this through its work toward the NCQA Multicultural Healthcare Distinction process. CHA will work with community and provider partners to identify those needing technical assistance and who are willing to partner with us through this process. We will conduct an internal and external readiness review concurrently according to our Health Equity plan which will inform this TQS project as to provider and partner readiness to proceed with the changes necessary to achieve the CLAS standards. This will be followed by a gap analysis against the NCQA Multicultural Healthcare Distinction guidelines. The gap analysis will compare current performance against the NCQA guidelines to highlight areas needing more focus and improvement. Improvement opportunities identified through the readiness review and gap analysis will fuel the implementation plan to complete all identified internal and external improvement opportunities. Upon implementation of all improvements, CHA will complete this project by applying for the NCQA Multicultural Healthcare Distinction.

With CLAS standard 13 being the primary standard addressed with the CLSP project, planned activities as outlined above, address the following CLAS standards:

- 3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
- 4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.
- 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- 6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- 8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.
- 11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- 12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): The Cultural and Linguistic Services Provision project activities include activities with external partners that complement the activities in the Health Equity plan:

- Identify provider and community partner(s)
- Conduct readiness review with identified partners
- Conduct gap analysis with partners using the NCQA Multicultural healthcare distinction guidelines as the gold standard for achieving CLAS standards

- Utilize CAC for readiness review and gap analysis process; leverage CAC for community education purposes and to support the CLSP project, activities within the project, and overall CLAS standards work.
- Create implementation plan from gap analyses and readiness reviews
- Implement elements from the implementation plan with partners

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Partner readiness review, gap analysis, and implementation

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
1 PCPCH clinic at tier 5	2-4 partners	05/2021	Same as target	Same as target
No readiness review has been conducted	Readiness review is completed	07/2021	Same as target	Same as target
No gap analysis	Gap analysis is completed	9/2021	Same as target	Same as target
No implementation plan	Implementation plan is developed	03/2022	Implementation plan executed	09/2022

Activity 2 description: Meaningful Language Access activity has 3 components:

- Monitor member utilization of language line services
- Translate member materials
- Train staff to improve cultural competence

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Translation, Language Line usage, and associated staff training

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Language line vendor that cannot collect member-level data	Contract with new language line vendor that has expanded data reporting capabilities	04/2021	Same as target	Same as target
Reporting process that does not include member-level data for language line use	Develop new language access reporting process	07/2021	Implement new language access reporting process; continuous monitoring of utilization and identification of	10/2021

			improvement opportunities	
Training plan for previous language line services	Revise training plan for interpreter services/language line based on new vendor for CHA staff and network providers	06/2021	Staff training completed Provider training completed	09/2021; 11/2021

Activity 3 description (continue repeating until all activities included): Workforce Development activities

- Recruit and hire 4 bilingual staff to increase the staff to LEP member ratio
- Recruit and hire additional Health Equity Staff (4) to lead CHA's transformation into a more culturally competent CCO
- Train staff on recognizing implicit bias and cultural responsiveness to further promote health equity for our members

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Recruit and hire health equity staff

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Cultural competence training plan in place	Revise current Cultural Competency Training Plan to correct deficiencies uncovered in gap analysis	09/2021	Implement revised Cultural Competency Training Plan	1/2022
2 bilingual staff	Hire 2 additional bilingual staff (total 4)	6/2022	Hire 2 additional bilingual staff (total 6)	12/2023
1 Health Equity staff	Hire an additional Health Equity staff (total 2)	7/2021	Hire 2 additional Health Equity staff (total 4)	6/2022
No targeted training curriculum for Health Equity staff	Create Health Equity training curriculum specifically for Health Equity staff	3/2022	Train Health Equity staff; ongoing annually	6/2022

A. Project short title: Diabetes Medication Management Program

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

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

B. Components addressed

a. Component 1: Special health care needs

b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

While this is a new project for 2021, groundwork in 2020 included the start of Cascade Health Alliance's (CHA) Improving Diabetes Hemoglobin A1c (HbA1c) through Social Determinants of Health (SDOH) Screening and Community Information Exchange (CIE) Implementation performance improvement project (PIP). The project addresses members' social needs through screening and connection to needed resources and services. By doing so, members will have more margin in life to better manage their diabetes and successfully lower their HbA1c. CHA case management, pharmacy, and customer service staff developed, were trained in, and tested the workflow with a small cohort of members. Case management and pharmacy staff are incorporating SDOH screening and resource connection into routine calls they are making with members diagnosed with diabetes.

In addition to targeted calls for SDOH screening and resource connection, customer service staff are inviting applicable members to opt into the [redacted] Diabetes Campaign through CHA's digital engagement platform [redacted] A study conducted by the School of Public Health, School of Social Welfare, and School of Psychiatry at the University of California, Berkley found that using diabetes management applications enhances medication adherence. Once enrolled, the program segments members into three risk categories based on insulin need and care compliance. The members then receive targeted diabetes care compliance information via text message. Case management and pharmacy staff were trained to enroll members in the education program and will do so when appropriate.

Through a root cause analysis exercise, the multidisciplinary PIP team identified medication adherence as a key area that requires improvement for members diagnosed with diabetes.

CHA's Director of Pharmacy performs an annual drug utilization review (DUR) on members diagnosed with diabetes and provides a per member letter to their prescribing provider including recommendations aligned with the American Diabetes Association (ADA) guidelines for diabetes treatment. A key recommendation that has seen little improvement is the use of statin therapy. The ADA has recommended statin therapy since 2008 for individuals diagnosed with diabetes if they meet a set of cardiovascular health indicators. The guidelines are based on trials such as the Collaborative Atorvastatin Diabetes Study (CARDS) that shows a benefit for statin therapy both as primary and secondary prevention of cardiovascular disease and mortality.

Addressing member's social needs, text-based education, and engaging providers through UR letters is not sufficient to tackle the complex problem of diabetes management, thus this new and more robust project.

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

For people living with diabetes, medication adherence is a critical aspect of successfully managing the disease and living healthier lives. Consequences of nonadherence include worsening condition, increased comorbid diseases, increased health care costs, and death. Medication nonadherence is not as simple as patients choosing not to take their medications. There is a difference between nonintentional and intentional nonadherence. Nonintentional factors include medical comorbidities, the healthcare system, and socioeconomic factors. Healthcare system factors include access to and trust in providers, provider communication skills, interpreter access, no or poor education materials

available to patients, actual and perceived treatment from staff across an individual's healthcare ecosystem, restrictive formularies, and more. CHA case managers are alerted automatically through Collective Medical when a hospital discharge occurs of a member diagnosed with diabetes. This provides systematic way to check in on medical care and social needs with the member. Unmet social needs, such as food, transportation, housing, and financial status, play a significant role in the health outcomes of people with diabetes. People need a range of interventions based on their individual situations and priorities. Additionally, the ADA recognizes that diabetes is a health disparity closely linked to social and economic disadvantage.

Medication adherence, taking medication correctly, incorporates several aspects and can be measured in multiple ways. The Center for Disease Control (CDC) outlines the core aspects as: medication therapy review, a personal medication record, a medication-related action plan, intervention or referral, and documentation and follow-up. CHA will focus improvement efforts through medication consultation and include key medication adherence aspects prioritized for members on the cusp of HbA1c control. The consultation will be conducted via phone conversations between a pharmacist and member and including other care practitioners via Healthy Klamath Connect (Klamath County's Community Information Exchange) and Reliance eHealth when appropriate.

Increasing medication adherence can also lead to lower per-member costs. Members diagnosed with diabetes account for 30.6% of CHA's Potentially Avoidable Costs (PAC) and represent a key opportunity for an intervention to improve overall health outcomes, specifically lowering their HbA1c. Diabetes medications were the most expensive drug category for the plan while ranking third in prescription count from July through September 2020.

E. Brief narrative description:

Cascade Health Alliance has hired an additional pharmacist whose role is to offer provider and member education and engagement targeted to members with diabetes. The PIP work discussed above will continue in support of this pharmacist-led medication management and chronic disease management program. Information gathered on individual member's social needs and education program enrollment is available to the pharmacist to consider during consultation with the member and/or the provider. The pharmacist will educate and engage members through medication consultations. The medication consultation target cohort is members on the cusp HbA1c control. The pharmacist will be conducting social needs screening according to the established workflow and connecting members with resources and services as appropriate, as well as enrolling members who consent in the [redacted] Diabetes Campaign through [redacted] Provider education will include presentations, conversations with providers, and articles in Care Talk (CHA's monthly provider newsletter). Effectiveness of education will be monitored by changes in provider prescribing behavior related to statin therapy. Communication will cover the topics of developing a comprehensive medication consultation program, research supporting formulary changes, and drug utilization review recommendations. Provider engagement will include collaboratively developing and implementing a communication workflow for shared patients.

CHA does not currently have a mechanism for measuring medication adherence rates. ATRIO Health Plans (CHA's contracted Medicare Advantage Plan) measures medication adherence by percent of plan members with a prescription for diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. CHA will develop this reporting capacity for its Medicaid line of business.

The first year of this project will be used to build the comprehensive plan including data collection and monitoring processes for medication adherence rates and cost. Policies and workflows will also be developed and implemented. Year two will include targeted efforts in medication adherence improvement and cost reduction.

Please see the attached documents:

- CareTalk Semglee2: article that appeared in CHA's monthly provider newsletter, CareTalk, in February 2021. CareTalk is distributed via email to providers on a monthly basis. The newsletter contains several brief articles with links for more information.

- Diabetes Project Preliminary Readiness Activities Summary
- Fishbone diagram developed as part of the supporting performance improvement project for this larger TQS Medication Management Program project.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Develop and implement a comprehensive diabetes medication consultation program.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Hire additional pharmacist; develop and implement a comprehensive diabetes medication consultation program, including policies, procedures, workflows, and reporting structure

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
One Pharmacist employed	Onboard an additional pharmacist with dedicated time for medication consultations	04/2021	Same as Target	Same as Target
No comprehensive plan	Comprehensive plan, documented policies and workflow	08/2021	Full implementation of program	12/2021
Targeted pharmacist consultation not occurring	20% of consulted members to show a reduction in HbA1c below 9 within 9 months of pharmacist encounter	12/2021 (rolling measurement based on date of each encounter + 9 months for HbA1c effects)	50% of consulted members to show a reduction in HbA1c below 9 within 9 months of pharmacist encounter	12/2022
[redacted] program not in place	36% of 414 insulin dependent diabetic members (150) recruited, screened, and opted into the [redacted] program; stratified by health risk and receiving targeted messages	6/2021	100% of 414 insulin dependent diabetic members recruited, screened, and opted into the [redacted] program; stratified by health risk and receiving targeted messages	3/2022
No statin use metric in place for tracking and reporting outcomes	Develop data collection and reporting method for the use of statin medication in members with diabetes meeting ADA criteria; baseline rate established	12/2021	25% increase in compliance rate among members in consultation and [redacted] programs	12/2022
No diabetes medication adherence	Develop data collection and reporting method for diabetes medication	12/2021	25% increase in compliance rate among members in consultation and [redacted] program	12/2022

measurement in place	adherence; baseline rate established			

A. Project short title: Community Integrated Risk Reduction and THW Sustainable Capacity

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

If continued, insert unique project ID from OHA: 59

B. Components addressed

a. Component 1: Behavioral health integration
b. Component 2 (if applicable): Serious and persistent mental illness
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

Cascade Health Alliance's (CHA) case management activities shifted during 2020 to provide outreach to all members at high risk for negative outcomes of COVID-19 should they become infected. That shift utilized case management resources from the beginning of the public health emergency in March through June. Case management staff stratified member lists by risk factors for focused outreach. CHA case management efforts are now focused on outreach and coordination of vaccinations for high-risk members as quickly as vaccine supply becomes available.

Despite limited human resources for case management purposes, significant progress was made towards Traditional Health Worker (THW) training and capacity building. While in-person trainings were cancelled, the community was able to hold a virtual certification training in collaboration with CHA's network Behavioral Health (BH) providers. The training resulted in all 23 attendees becoming certified as THWs, thus increasing the capacity in the surrounding community.

A key community partner in treating alcohol and other drug (AOD) disorders, Transformations Wellness Center, obtained a Substance Abuse and Mental Health Services Administration (SAMHSA) grant in early 2020 with the aim to decrease emergency department (ED) utilization using Peer Recovery Support Specialists (PRSS). PRSS' have expanded training in addition to the core Peer Support Specialist curriculum. This opportunity added four THW staff to their clinic. The grant supports peers working directly with patients who present to the ED with an AOD related condition. The ED notifies Transformations Wellness Center who then dispatches a PRSS to the ED. The PRSS makes face to face contact with the member to initiate the support process and encourages assessment and treatment if appropriate. Support also includes introduction to 12-step programs and other community resources identified to ameliorate consequences of AOD use/abuse. Due to COVID-19 restrictions however, this work was halted for most of the year. Transformation Wellness Center PRSS' will commence work once workplace restrictions allow.

CHA continued to build its relationships with network BH providers through performance improvement activities, strategic planning, and supporting providers through the challenges of adopting telehealth and staged opening of in-person services. CHA successfully implemented Health Klamath Connect (HKC), a Community Information Exchange (CIE), to screen members and connect them to needed services. HKC allows CHA to accurately track closed-loop referrals to ensure members receive the services for which they were referred. Also during 2020 was an increase in the onboarding of our providers into Collective Medical which has allowed for more coordinated efforts to case manage high ED utilizers across the community.

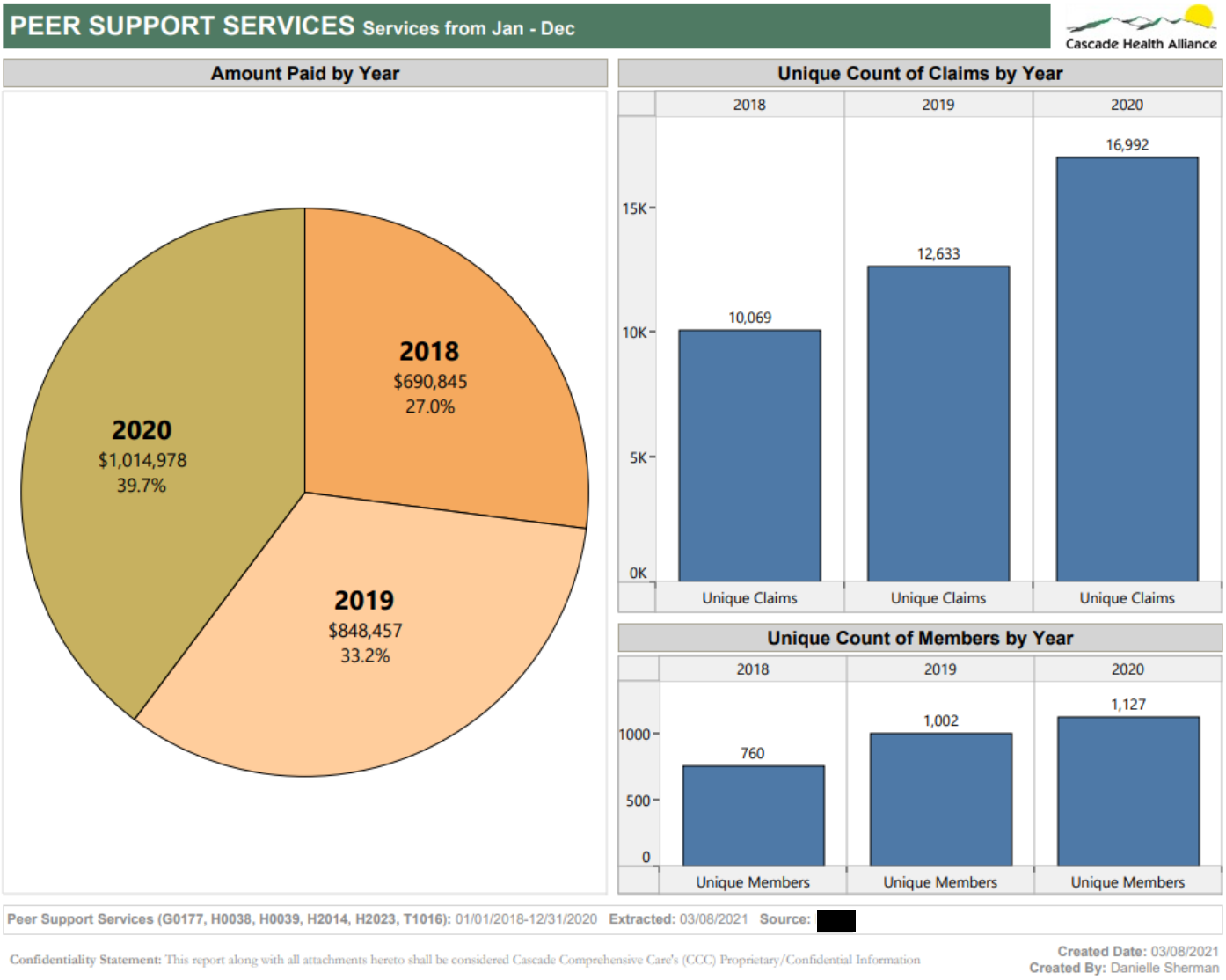
CHA staffing challenges were overcome by hiring Registered Nurses (RN) outside of our service area who were willing to work remotely. This resulted in the addition of three new case managers.

For this project specifically, a cohort of 58 members for intervention was identified by CHA's Case Management department in 2020, with 23 of those members receiving targeted case management during the review period. As seen in the table below, while there was an increase in the number of ED visits among this cohort during the measurement period between September 2020 and February 2021, there was a $76,700 reduction in avoidable costs during the same time frame as shown in the table below.

		SPMI/SUDS & Chronic Disease Cohorts (Diabetes or CHF, or COPD, or Asthma)		
Total number in Cohort is 58				
Number of Cohort receiving case management services during the 6-month period is 23				
		Case Managed Cohort Beginning in September 2020	Case Managed Cohort Reviewed in February 2021	Difference
	Total Avoidable Costs:	$212,200.00	$135,500.00	$76,700.00
	ED Visits Prior 12 months	268	264	4
	ED Visits Prior 3 months	53	72	-19

CHA was not awarded the grant for which they applied to build a THW training curriculum in collaboration with Klamath Community College, therefore this initiative is currently on hold.

In spite of the challenges brought by COVID-19, the use of THWs increased from 12,633 distinct claims in 2019 to 16,992 in 2020 (January thru December), with an 19.6% increase in claims annualized paid over the same reporting period, as shown in the table below. Also of note is a 12.5% increase in the number of unique members utilizing THW services in 2020 (1,127 unique members) over 2019 (1,002 unique members).



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

This project's work began as part of CHA's ED Utilization Performance Improvement Project (PIP) since data clearly demonstrated the need to manage high utilizers among the severe and persistent mental illness (SPMI) population as well as those presenting to the ED with an AOD related condition. In Q1 2020, the PIP was closed and work transitioned to supporting BH providers in building the community's THW capacity so peers can work directly with this challenging population.

Data on THW utilization is currently captured by claims and provider reporting which in its current form does not identify the unique number of members receiving services, only an overall total of services rendered. This will be remedied in 2021.

CHA continues to have strong collaborative relationships with network BH providers and convenes the group monthly to review metrics performance, share best practices, address system gaps (i.e., ED utilization, HIE utilization, use of Collective Medical, etc.), and identify improvement opportunities and barriers to care that need to be addressed. Network BH providers are highly invested in increasing THW capacity in the community and leveraging their services to provide supports such as transportation for members. In our rural/frontier community, these supports are vital to connect members with other needed services and supports such as food, housing, BH and medical appointments, and

the local community action committee. THWs also share the wealth of knowledge, tools, and skills that come from their lived experience.

Discussed above and in other projects is the implementation of a Community Health Exchange, Healthy Klamath Connect (HKC), an online platform (Aunt Bertha) to connect community members to needed services provided by local Community Benefit Organizations. HKC makes it easy for providers who identify members with social needs (SDOH) to find resources and make referrals to appropriate programs and services such as food, shelter, health care, employment, financial assistance, and more. The platform includes a closed feedback loop to track referrals and receipt of services. Additionally, CHA submitted an application for a SAMHSA grant which if approved will provide for the HKC license in our community to be upgraded to an "enterprise" license. This upgrade would allow providers to enter referrals through HKC directly into provider and/or clinics' EHRs. This would greatly improve the system by automating current processes by allowing provider/clinic EHRs and HKC to speak directly to each other minus the additional login step.

Please see the attached document, Healthy Klamath Connect, for more information.

The work outlined here aligns with the work accomplished in the past year within CHA's case management department in terms of process and workflow development in compliance with the requirements of CCO 2.0. 2021 will build on that work as we upgrade our case management platform to more robustly track our identified cohort and collect data to help us better manage, measure, evaluate, and escalate interventions with our most vulnerable members.

E. Brief narrative description:

CHA will continue to provide THW services (and build capacity) through its five partnerships (3 BH providers, 1 PCPCH, and Sky Lakes Medical Center).

Transformations Wellness Center will continue its work in the ED as COVID-19 restrictions are eased. Now that the capacity to provide trainings within an online environment has been established, trainings will continue to be held in collaboration with our BH community to further increase the community's THW capacity by 20 FTE in 2021. Additionally, CHA will continue to work with Collective Medical to establish cohorts within the system to better track the SPMI population's utilization of services, and those needing immediate follow up after a behavioral health crisis and/or ED visit. The current identified cohort consists of 40 CHA members. Parameters for cohort identification according to risk will be revised to increase the cohort participation. The protocol for the intervention will also be expanded to include a records review, pharmacy consultation, creation of the cohort in Collective Medical, expanded use of Reliance eHealth, and case staffing within the appropriate Interdisciplinary Team.

CHA was awarded a System of Care grant which will further expand our ability to provide THW certification training in our community in 2021. This effort will include training Doulas.

CHA will enhance its reporting capability to better determine under/over utilization of services, effectiveness of interventions targeted to this population, including the following metrics in addition to what is currently gathered (noted below under Activity 2):

- Potentially avoidable cost for case managed cohort vs non-case managed cohort, including delta and trendlines
- Members declining case management services vs. those offered (members are defined as meeting criteria but declining or dropping case management)
- ED utilization by diagnosis (presenting and discharge) for case managed cohort members vs. non-case managed cohort (members are defined as meeting criteria but declining or dropping case management)
- Number of members receiving referral to THW as an intervention; accepting or declining referral

CHA will continue to follow its THW Integration and Utilization Plan to further increase THW capacity in the delivery network, including evaluation of best practices, internal policy and procedure development specific to THW care coordination and monitoring of THW service utilization. Additionally, CHA will continue to identify measurable outcomes for THW utilization to better capture and measure the effectiveness of THW services not currently captured via encounter claim data. As our reporting requirements increase to include more accurate and stratified data regarding THW utilization in our community, CHA will create an active tracking and reporting system to allow for a more precise method of capturing key data points, i.e., how many providers utilize THWs, number of independent THWs are active in the community, and how many unduplicated members are receiving THW services.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Use predictive analytic platforms/tools to identify the target cohort; assign the cohort members for case management; develop targeted, individualized, integrated treatment plans.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Continue to identify cohort members; establish targeted and individualized treatment plans for each member of the cohort.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
40 members in cohort	Increase cohort to 75 members due to expanded inclusion criteria	6/1/2021	Maintain Cohort of 75, as new members meet criteria	12/31/2021
Cohort Identified, currently 23 with active treatment plans.	Establish treatment plans with identified targeted interventions for each remaining cohort member to bring the total to the current cohort of 40; update interventions/escalations in previous cohort members' (original 23) treatment plans	6/1/2021	Active treatment plans for all 75 cohort members.	12/31/2021.

Activity 2 description: Monitor cohort to measure reduction in risk based on targeted interventions. Targeted interventions are individualized with achievement based on individual member performance. Risk reduction for the entire cohort monitored on a monthly basis with performance used to inform PDSA cycles for continued improvement opportunities.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Identify metrics and database; create reporting platform; review and analyze data.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

Cohort metrics include number of members identified, number with active case plan, potentially avoidable costs and ED visits.	Additional metrics identified, reports built, including visualization.	9/1/2021	Metrics aggregated, reviewed, and analyzed monthly.	12/31/2021
2019 rate of Emergency Department utilization among members with Mental Illness: 98/1000 (lower is better)	96.90 (lower is better)	12/2021	86.5/1000 (lower is better)	12/2022

Activity 3 description (continue repeating until all activities included): Increase community capacity of THW/CHW/Peer Recovery Mentors/Support Specialists through curriculum development, execution of program; create mechanism for sustainability of education and certification program.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Monitor the number of both newly certified and continued service independent and clinic associated THW/CHW/Peer Recovery Mentors/Support Specialists.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No 2021 THW trainings scheduled	Schedule THW training	4/30/2021	THW training held	9/30/2021
Scholarships and wage reimbursement not available for training	Create system for scholarship determination and wage reimbursement application and awards	4/30/2021	Award scholarships and wage reimbursements for those who qualified	9/30/2021

A. Project short title: Comprehensive Utilization Plan and NEMT

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

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

B. Components addressed

a. Component 1: Utilization review
b. Component 2 (if applicable): Access: Quality and adequacy of services
c. Component 3 (if applicable): Access: Timely
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

In 2020, the Utilization Review component was included in OHA Project #60: Oral Health Care Coordination for Vulnerable and At-Risk Populations. Improvements in dental services utilization were challenging in 2020 due to the Public Health Emergency and subsequent closure of dental offices. Additionally, dental offices were slow to re-open due to a lack of required PPE and the length of time it took to acquire the items needed to safely resume the provision of services. Once it was deemed safe to resume services, CHA deployed its [redacted] ([redacted]) to work in the local pediatric dentistry clinic to assist the clinic in getting caught up with the back log of patients from the closures. [redacted] also provided services to pregnant women and new mothers at Klamath County Public Health (WIC program) as they were unable to return to providing services in the schools. [redacted] also provided services to young children at Head Start during Q3 and Q4 of 2020. Prior to Covid-19, CHA's pharmacy department reviewed members' oral health needs at the time members picked up their diabetic supplies from our office or during routine check-ins via telephone. Pharmacy staff also assisted members in completing new patient paperwork for their assigned dental home, as well as assisting members in making appointments with their dental provider to establish care. This work will continue when CHA offices re-open to members. Until then, both case management and pharmacy staff continue to assess members' oral health needs during regular check-ins via telephone. The TQS work was supported by a Performance Improvement Project in collaboration with the Klamath Basin Oral Health Coalition (KBOHC). The PIP was closed as successfully completing its objectives in Q4 2020, with the work being sustained by the KBOHC. Therefore, this project has been closed and resources allocated to other initiatives.

In 2020, the Access: Quality and adequacy of services and Access: Timely domains were secondary components in the Member Reassignment project (OHA Project #61), which was a continuation of the Appeals and Grievances project begun in 2018 and 2019. Improving the process for member dismissal and reassignment is a priority to ensure that members have timely access to providers so as not to delay needed services. During 2020, CHA added member reassignment requests to the data collection and reporting structure for tracking grievances and appeals. Reporting structure now includes this information in quarterly grievance and appeals dashboards. The secondary activity focused on provider education and expectations for reporting to CHA when providers dismissed members from their practice, as this information was submitted to CHA on an inconsistent basis and not in a standard format, making aggregation of provider data challenging. An informal system is in place to capture member reassignment due to member dismissal by a provider, however the establishment of a formal tracking system remains as part of the continuation of that project.

The Public Health Emergency delayed provider training until late in the 2020 calendar year as both provider and CHA attention was focused on our community Covid-19 response. The Dismissal of Care template was created and expectations for its use included in the November 2020 provider training via a virtual platform. Because only 16.2% of CHA's active network providers to date participated in the training and attested to receipt of the information regarding member reassignment, grievances and appeals, and reporting requirements, provider training remains as a monitoring activity for 2021. Consistency of provider reporting of member dismissal continues to be validated. Incomplete work on the member reassignment process continues under the Appeals and Grievances project (OHA project #61).

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

With 20,724 members as of July 31, 2020, CHA's ratio of CHA providers to members with physical health coverage is 1:129 for primary care providers (physician and non-physician), 1:715 oral health provider, and 1:102 for mental health providers. Per the 2020 County Health Rankings, the Oregon average ratio of providers to patients is 1:1060 for primary care physicians, 1:1143 for non-physician primary care providers, 1:1250 oral health provider, and 1:190 for mental health provider while Klamath County's ratio of providers to patients is 1:1050 for primary care physicians, 1:1057 for non-physician primary care providers, 1:1170 oral health provider, and 1:210 for mental health providers. Of note, the Klamath County ratios do not account for services provided to people seeking care from nearby counties. On the

surface, CHA's provider to member ratios appears sufficient as they are lower than the state average. However, when determining access needs, CHA must consider the population of the entire county as the healthcare system provides services to individuals who are not enrolled in CHA. Additionally, CHA's member enrollment has the potential to grow. Because it can be difficult to recruit additional providers to a rural community, CHA should focus access improvement efforts on addressing over- and underutilization of services and workflow inefficiencies while better utilizing the time and skills of providers CHA currently has in its network.

Inefficient use of healthcare services (both under and over utilization of services) affects access by decreasing the availability and timeliness of appointments, diminishing cost-effectiveness of the healthcare system which ultimately lowers the quality of care provided and leads to avoidable costs. Appropriate utilization management provides a comprehensive view of how efficiently and effectively the healthcare system is performing through a thorough review and analysis of services provided to identify areas of inefficiency in need of improvement (such as the provision of low-value services), targeted education opportunities for both members and providers, with the goal being improved member health outcomes and experience.

CHA's utilization management program currently includes authorization and utilization review of medical, behavioral health, dental, and pharmacy services with review conducted by each separate department, with overall oversight by the Chief Medical Officer, the Utilization Review Committee (URC), and Pharmacy and Therapeutics (P&T) Committee. Utilization review of NEMT services is not currently conducted to the same degree. Consultation with and an audit by the Center for Case Management in January of 2020 recommended that CHA implement a process for concurrent utilization and authorization reviews.

CHA UR staff spend majority of their time processing and reviewing authorizations. While this does allow for timely authorization review, it does limit opportunities for analysis of utilization trends. [redacted] and Utilization Review Committee members are instrumental for appeals and reconsiderations (provider appeals).

Several methods are currently used to monitor utilization within the provider network. However, data is reported in multiple formats and reports with some being inconsistently produced for review. CHA consistently tracks utilization for certain services but does not currently take a holistic approach to monitoring utilization leading to a lack of analysis and identification of improvement opportunities. CHA provides monthly performance dashboards to providers which detail performance toward the incentive metrics targets by clinic, as well as risk scorecards which include ED and generic drug utilization. CHA's annual provider audits include a chart review to ensure services are accurately documented, services and diagnoses are appropriate and evidence based, and CHA's clinical practice guidelines are followed. Condensing information into fewer reports/dashboards while also providing analysis of and insight into the information to make it more actionable by providers will increase the organization's efficiency and allow for more meaningful communication with providers to improve service provision to members.

CHA strives to include as many providers and services within the network as possible to meet member needs. If CHA does not have a service available locally, it is typically due to the constraints of being a small rural community. In this instance, members are directed to the closest service provided out-of-area. Any member who requests a second opinion is permitted to have one. CHA ensures the network offers timely and quality access to services for members while monitoring utilization of services through the collection of data from multiple sources. These sources include, but are not limited to, member grievances, CAHPS surveys, annual provider audits, claims data, member demographics and enrollment data, time and distance data, and data from subcontractors and subdelegates. CHA's annual provider audits verify that clinics offer ADA accessibility as well as access to emergent, urgent, and after-hours care. If an issue develops that warrants action or a gap is identified, Corrective Action Plans are developed along with strategies, target dates, deliverables, and additional monitoring programs to address any deficient services.

According to the July 2020 DSN report, more than 93% of members live within 60 miles of any provider type which is above the 90% requirement of a rural community based on OHA travel time and distance standards. Regardless, reliable transportation continues to be a barrier for members in accessing healthcare. The "No-Show Project" conducted in 2017 in collaboration with the Oregon Institute of Technology showed transportation as one of the barriers to members successfully attending scheduled healthcare appointments. A recent gap analysis of non-emergency medical transport (NEMT) services conducted in 2020 identified significant improvement opportunities.

Sky Lakes Medical Center (SLMC) contracts with TransLink to provide NEMT services for CHA members. The NEMT network consists of 26 subcontractors, 272 certified subcontractor vehicles, and 355 drivers as of March 2020. During first quarter 2020, prior to the Public Health Emergency, 11,430 rides were completed for 583 (average) unique CHA members as shown in the chart below. About 170 to 300 same day rides were scheduled per month in 2020. CHA estimates that utilization would have been similar in the remaining quarters of 2020. Given the number of eligible members (average of 19,558), utilization of NEMT is low (average of 583 as noted above) while the no-show rate is high with nearly as many no-shows (average 491) as completed rides. Access to NEMT allows members to receive primary and secondary care that may have otherwise been inaccessible due to a lack of transportation. The underutilization of NEMT services requires further investigation to determine its root causes and necessary corrective actions.

NEMT Program

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Allowed Events:									
Shared ride	578	782	573	264	304	340	313	273	249
Driver no-show	2	2	0	0	0	2	1	1	3
Client no-show	148	194	149	54	49	58	54	67	51
Client cancellations < 24 hours prior	1328	1086	2012	1420	906	821	789	814	759
Driver cancellations < 24 hour prior	0	0	0	0	0	0	0	0	0
Same day rides scheduled	291	218	236	166	206	206	170	170	168
Rides scheduled	3,210	3,248	2,616	1,273	1,495	1,862	1,864	1,821	1,869
Denied - Non-covered service	24	6	12	1	3	5	3	6	6
Denied - Other resources	16	4	7	0	0	0	0	0	0
Denied - Not Eligible	16	4	8	0	0	0	0	0	0
Denied - Unable to verify appointment	16	4	7	0	0	0	1	0	2
Denied - Court ordered	16	4	7	0	0	0	0	0	0
Denied - Same Day Not Urgent	0	0	0	0	0	0	0	0	0
Rides to non-Covered Services provided under Health Related Services	312	300	139	3	6	1	4	3	6
Rides to Non-Covered Services - Other	336	0	1	6	6	11	9	16	6
Rides to non-Covered Services (Total)	648	300	140	9	12	12	13	19	12
Hospital Discharge Pickups - Total	44	21	37	25	25	31	33	25	31
Enrollment - Eligible Members Enrolled	19,324.55	19,734.07	19,615.39	19,525.44	20,391.91	20,542.70	20,578	21,091	20,935
Members Served - Unique Members Using Transport	618	606	526	279	343	432	449	428	431
Utilizaton Rate - percentage of service usage	3.20%	3.07%	2.68%	1.43%	1.68%	2.10%	2.18%	2.03%	2.06%
Added by SLMC-OPCM: DENIED - Outside of Service Area	20	5	8	1	2	1	4	1	1

Of the 272 vehicles in the fleet, 139 are wheelchair accessible. According to the Medicaid and CHIP Payment and Access Commission, certain member populations are more likely to utilize NEMT services, such as disabled patients (26.4% of ride-days) and elderly patients (22.2% of ride-days). In the first quarter of 2020, 11.4% of unique CHA members utilized a wheelchair accessible van accounting for 8.6% of rides provided. While CHA's NEMT network consists of several wheelchair-accessible vehicles, one healthcare clinic reported they provide NEMT services but are unable to provide NEMT services to patients who must remain in a wheelchair. Some Traditional Healthcare Workers as well as the local bus company and senior center also provide transportation to appointments. NEMT services are especially important in the winter when the rural road conditions in Klamath County are more difficult to navigate, presenting an additional barrier for CHA members who may not have access to a four-wheel or all-wheel drive vehicle.

The Outpatient Care Management (OCM) Department at SLMC conducted an audit of TransLink's NEMT services in January 2020 to assess the adequacy, quality, and timeliness of current service. Several strengths were identified, including TransLink's ability to implement service modifications, a grievances and appeals process, a good safety record,

and ability to provide timely services so members have sufficient time to check-in and prepare for appointments. However, TransLink scored "partially compliant" for the NEMT Quality Assurance Program due to the lack of a formalized quality assurance plan and quality oversight being delegated to providers rather than regulated by TransLink directly. Additionally, several weaknesses were identified, including a lack of records for vehicle equipment and maintenance, CHA member reports of poor driver professionalism, and increased wait time for pick up due to drivers' extenuating circumstances, and inadequate data collection and reporting processes. Furthermore, TransLink requires that NEMT rides are requested minimally 48-72 hours and up to 90 days in advance for most services. Same-day NEMT services are limited to urgent care, hospital discharge, secure transports, ER visits, appointments scheduled same-day, and/or if physician or mental health requests a same day appointment. This can present a barrier to members receiving timely care if member do not understand these requirements.

Communication between CHA and TransLink is an identified improvement opportunity. Improved communication will better assist CHA in providing technical assistance to TransLink in being compliant with contractual requirements for data collection and reporting processes. While some of the requested TransLink Reports are incomplete (2019 Quarter Preliminary Report), some are missing altogether (2020 Quarter 1 Performance Report, Member Satisfaction Survey and Outcomes Report). Although TransLink is currently working to improve its data collection processes, CHA must provide more intensive technical assistance to TransLink to improve reporting capabilities so we can better provide our members with adequate, high-quality, and timely services.

E. Brief narrative description:

To ensure adequate and timely access to appropriate medical services, CHA will implement a more robust utilization management program to include improvements to the prior authorization process, expansion of utilization reporting including trending with benchmarks, expanded report dissemination and transparency, identification of overutilization and underutilization of services and interventions to address opportunities for improvement. Leadership will review the quality, quantity, and appropriateness of medical services monthly with support from the Utilization Review Committee. Medical service utilization will be evaluated both in the context of historical CHA trends and also benchmarked against similar Medicaid populations with similar benefit packages. Significant concerns with overutilization (e.g., ER use) or underutilization (e.g., preventive services) will be addressed by the case management department, the Network Management Committee or the Utilization Review Committee as appropriate. Significant concerns with quality will be referred to quality management department or the Quality Management Committee for assistance with a performance improvement plan. The utilization management program will address multiple factors of realized access which are availability, accessibility, and accommodation. A gap analysis may be conducted to identify additional improvement opportunities.

Since reliable transportation continues to be a barrier for members in accessing timely healthcare, utilization management process changes will be piloted by prioritizing NEMT services, including an evaluation of utilization and experienced access. The project will include evaluation of other available types of transportation and offer member and provider education, as necessary. CHA will use lessons learned from the NEMT project to support further advancement of the utilization management program.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Expand utilization report content and production frequency for monthly for plan level and provider level reporting. Phase one key utilization and access metrics include emergency room, hospital, primary care, specialty care, and behavioral health, and ancillary utilization. Reports are trended with relevant benchmarks. Phase two detailed reporting includes drill down into phase one report elements as indicated.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Report production

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Limited reports are produced with a monthly cadence. Many reports are run on an as needed basis.	Phase one reports are produced monthly by plan, and by PCP, dental and BH providers.	06/2021	Phase one and two reports are produced monthly by plan, and by PCP, dental and BH providers. and include Medicaid benchmarks.	11/2021

Activity 2 description: Expand inter-rater reliability (IRR) checking of prior authorizations to include medical, dental, and behavioral authorizations. Findings of reliability below 85% are referred to the case management department for process improvement.

☒ Short term or ☒ Long term

Monitoring activity 2 for improvement: Prior authorization inter-rater reliability

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
IRR testing is done for dental PAs but is no longer done for medical or BH authorizations.	IRR testing is done monthly for all dental, medical and BH authorizations.	06/2021	Monthly IRR is consistently greater than 85% for authorizations	3/2022

Activity 3 description: Creation of comprehensive utilization report packet for internal dissemination to identify improve opportunities.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Internal report dissemination

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Leadership receives multiple reports with utilization and access data	Phase one utilization reports are distributed to leadership monthly and included in a comprehensive	06/2021	Phase one and phase 2 utilization reports are distributed to leadership monthly and included in a	3/2022

	packet; identify opportunities for improvement		comprehensive packet; identify opportunities for improvement	

Activity 4 description (continue repeating until all activities included): Collaborate with community and provider partners to address any deviations in utilization.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Identification of overutilization and underutilization of services and interventions to address opportunities for improvement.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Overutilization and underutilization of services is identified when deviations are significant.	Overutilization and underutilization of services is identified earlier due to trending and comparison with benchmarks.	08/2021	Community and provider partners participate in interventions to address any deviations in utilization.	1/2022

Activity 5 description: Improve member understanding, experience, and utilization of NEMT services while better capturing and reporting NEMT data.

☒ Short term or ☐ Long term

Monitoring activity 5 for improvement: Using preliminary procedure from activity 1, improve data capture, collection, and reporting to ensure accurate, actionable, and timely data on the utilization of NEMT services is available.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No consistent data reporting on NEMT utilization	NEMT utilization report produced monthly; review by Utilization Review Committee, improvement opportunities noted and acted upon.	7/2021	NEMT utilization reports are shared and discussed with NEMT Provider quarterly, improvement opportunities noted and acted upon with discreet deadlines	9/2021
How to access NEMT services outlined in Member Handbook	Increase member outreach regarding utilization of NEMT services via digital engagement, social media, blogs, and	9/2021	Same as Target	Same as Target

	improved visibility on website			

A. Project short title: Collaboration and Care Coordination for LTSS FBDE Population

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

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

B. Components addressed

a. Component 1: Special health care needs
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

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

The previous Special Health Care Needs (SHCN) Project focused on Oral Health Integration (OHA Project #60) - Care Coordination for Vulnerable and At-Risk Populations, specifically members with diabetes who have comorbid chronic or complex conditions, and members who are pregnant. The main objectives of that project having been met and the work now being sustained through the Klamath Basin Oral Health Coalition, Cascade Health Alliance (CHA) has chosen to reallocate its resources to two new SHCN projects, maintaining the focus on members with diabetes in one, and the other focusing on those receiving long term services and supports (LTSS). Examples of the previous SHCN project work product are attached to the 2021 Oral Health Integration Project.

During the last year and a half, the targeted full benefit dual eligible (FBDE) long-term services and supports (LTSS) population was case managed per the model of care (MOC) as written for all FBDE members. A written health risk assessment (HRA) was mailed to the member with a request to complete it and mail it back. If the HRA was not returned within thirty days, up to three telephone calls were made to members to try and complete the HRA over the phone. All members were mailed a care plan with goals based on their health status and additional follow-up with their assigned nurse case manager was scheduled within three to six months.

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

Cascade Comprehensive Care (CCC) is a health care management company that operates Klamath County's coordinated care organization (CCO), CHA, and serves as a local administrator for ATRIO Health Plans, a Medicare Advantage (MA) plan. CCC, in collaboration with ATRIO Corporate, manages care for 720 full benefit dual eligible (FBDE) members (as of July 2020) who are enrolled in both CHA and ATRIO's Special Needs Plan (SNP). Of these FBDE members, 175 receive LTTS services (24.3%). All FBDE LTTS members were mailed a Health Risk Assessment (HRA) within the past 12 months; however, only 74 (42%) of those LTTS FBDE members completed the HRA; 101 (58%) members either 1) refused to complete the HRA or 2) did not return the HRA and were unable to be reached by telephone. Records of all 175 LTSS FBDE members show they were being actively case managed (HRA, tailored individual care plans, and scheduled follow-up) by a nurse case manager.

In 2019, 19.9% of Klamath County residents reported having a disability, and 21.7% of the population was over the age of 65. Changing population demographics in Klamath County indicate a growing need for LTSS. In 2019, 19.9% of Klamath County residents reported having a disability, and, in 2020, 19% of the population was over the age of 65. However, Oregon's Department of Human Services (DHS) projects that the 65+ population in Klamath County will grow to approximately 21% by 2030. To address the projected increasing demand for LTSS, ATRIO and CHA must enhance its current program to sustain a high-quality array of services for their members.

LTSS is divided into two categories: home and community-based services (HCBS) and institutional services. With HCBS, LTSS can be delivered in a home or community setting (such as a group home) while institutional LTSS indicates that a person is receiving care in an institution (such as a skilled nursing facility) that may not be in the patient's community. Most ATRIO and CHA members in Klamath County who utilize LTSS utilize community-based programs that enable them to live at home or in local settings while maximizing their health, independence, and quality of life. Of the FBDE members receiving LTSS, 1% receive care in an institutional setting, 66% receive in-home care, and 29% receive community-based care. Since HCBS is preferred in most cases, ATRIO's and CHA's rates are better than the state average. According to DHS, Oregon served 35,000 Oregonians in Medicaid Long-term care during 2019: 18,800 in LT Medicaid in-home services (53.7%), 11,800 in community-based care (33.7%), and 4,400 in skilled nursing facilities (12.6%). Due to Oregon's high utilization of HBCS LTSS, the populations receiving in-home care have increasingly intensive services and support level needs. CHA includes caregivers in interdisciplinary team (IDT) meetings, care plan goal setting and discussions to increase support of their work. From Aging and People with Disabilities (APD) and Developmental Disability Services (DDS), CHA can request a copy of a caregiver's service plan for review of unaddressed needs.

Of the $8,877,365,993 spent on Oregon Medicaid in 2018, Oregon spent 32.5% ($2,882,307,719) on LTSS, or $689.24 per resident. In addition, 83.4% ($2,403,110,660) of the total state spending on LTSS is comprised specifically of HCBS. This is higher than any other state. Since there is limited data for LTSS spending in Klamath County specifically, statewide data is used to estimate costs in Klamath County. With a 2019 population of 68,238, this would suggest that the spending for LTSS in Klamath County was approximately $47,032,259 in the same year. While the demographics in Oregon and Klamath County are similar for disability (24% and 20%, respectively) and the 65+ population (19% and 18.5%, respectively), this estimate may still be impacted by other factors and should be considered with caution.

LTSS members require access to the care they need when they need it the most. There is limited evidence demonstrating the effectiveness of care coordination specific to the LTSS population; however, LTSS managed care is the direction the industry is heading under the direction of CMS. According to the American Association on Intellectual and Developmental Disabilities (AAIDD), people with intellectual and developmental disabilities (IDD) visited the ED less often if they were receiving managed care, LTSS included. Per the Agency for Healthcare Research and Quality (AHRQ), the Institute of Medicine identified targeted care coordination as having the potential to improve the effectiveness, safety, and efficiency of the healthcare system and improve outcomes for patients, providers, and payers. Thus, LTSS care coordination works to reduce unnecessary ED utilization and recurrent hospitalizations, improve access to primary care for preventive services, and support early identification of changing health care needs leading to a reduction in medical crisis management and opportunities to improve member health and quality of life.

Currently, CHA lacks a reporting mechanism to inform ATRIO Health Plans for those shared FBDE LTSS members who are being case managed, and the tracking of LTSS members is haphazard. Members are identified through health risk screenings, authorizations for services, or appearance in Collective Medical. They have not previously been tracked as a separate population from the general CHA membership. ATRIO currently identifies LTSS members when a case manager reaches out to the member to complete an initial or annual care plan, to complete a transfer of care, or for previously scheduled case management follow-up. Although CCC and ATRIO regularly collaborate to meet the needs of LTSS members, the infrastructure to collaborate across lines of business consistently and efficiently for purposes of screening and providing care coordination services is lacking. CHA and ATRIO care management platforms are not interoperable,

making it challenging for each entity to access progress notes, treatment plans, or confirmation that a member is being actively managed by one entity or the other. Each entity is conducting assessments and collecting information often from the same member leading to multiple contacts with members, and ultimately, frustration of members with the number of duplicate contacts. CHA and ATRIO each have a designated case manager who monitors Transfers of Care, including discharges from short-term and long-term hospital and institutional stays, and generating member care plans when needed. Both CHA and ATRIO monitor members at higher risk for readmissions and refer members to additional case management as appropriate. Despite both organizations having these systems in place, CHA and ATRIO have not previously worked collaboratively to monitor transitions of care plans nor to reduce hospital readmissions.

CHA and ATRIO have discussed improving workflows to alleviate these challenges, but to date, action has not been taken. In addition to improving the process by which LTSS members are managed, CHA and ATRIO will establish a similar partnership and process with APD. Even though CHA has been included in care conferences where APD was present, CHA has not otherwise engaged with APD to provide services to members. The revised a Memorandum of Understanding (MOU) with Aging and People with Disabilities (APD) will assist in improving this process. In Klamath County, APD fulfills the role of the Area on Aging (AAA). The MOU will guide future collaboration and information sharing between APD and CHA for members with LTSS while enhancing integration of services. The MOU will improve member experience by supporting the comprehensive collaborative care coordination plan referenced in section E.

E. Brief narrative description:

In collaboration with ATRIO Health Plans, Cascade Health Alliance (CHA) will create a comprehensive collaborative care coordination plan to include:

- Identification of members in need of or currently receiving Medicaid funded LTSS services (be they Medicaid primary or FBDE covered)
    - High health care needs
    - Multiple chronic conditions
    - Mental illness or substance abuse disorders
    - Functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities
    - LTSS members who otherwise meet SHCN population as defined by the OAR.
- Revise current processes and workflows for service provision, coordination (including the identification of barriers to care, coordination with the member's PCP and other applicable parties, medical treatment plan compliance, medication compliance, disease-specific teaching, and identification of social determinant of health needs), follow up, and monitoring of members
- Reduction in duplication of services (including services related to discharge planning for short-term and long-term hospital and institutional stays)
- Comprehensive data monitoring and analysis plan to include:
    - Outreach efforts and members engaged in services
    - Services provided
    - Members served and actively case managed
    - ED utilization (per contract)
    - Depression Screening and Follow-up (per contract)
    - Plan All-Cause Readmissions (per contract)
- Identification of improvement opportunities.
- Formal staff training curriculum development based on Atrio's SNP Model of Care (MOC)
- Mutual accessibility to all member information and reporting

Streamlined process will lead to improve contact with and screening of LTSS members, improve care coordination, reduce all-cause readmissions, increase screening for depression and follow-up, and decrease avoidable emergency

room utilization. Through joint case management, FBDE members will be identified by cross referencing the LTSS reports received from the state in addition to information received from Health Risk Assessments. Data collected in the first six months of the project will be used as the baseline for quality improvement efforts starting in Q3 2021, and the establishment of improvement targets moving forward.

CHA and ATRIO will enroll identified members in appropriate Case Management program to address care coordination needs with a person-centered plan of care developed in collaboration with the member and/or caregiver and reviewed in monthly Interdisciplinary Team (IDT) meetings to ensure appropriate coordination and provision of services. Interdisciplinary care teams will include providers that are relevant to the members health care needs, and at minimum the member and/or designated caregiver, Primary Care Provider, and Nurse Case Manager. Other care team members may include, but not limited to, long-term care community nursing (LTCCN) services, Aging and People with Disabilities (APD), Developmental Disability Services (DDS) supports, adult foster homes, and assisted living facilities. The team will address member access to appropriate providers (i.e., primary health, specialty, behavioral health, and dental providers), reduction in barriers to care, identification of local resources, and addressing polypharmacy. Members will be connected with local resources as needed through Healthy Klamath Connect (Community Information Exchange) which has a closed loop referral system to ensure members receive services.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Infrastructure development

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Develop comprehensive collaborative care coordination plan

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current formal agreement with APD.	Enter in formal MOU agreement with APD.	04/2021	APD provides monthly updates to CHA.	05/2021
No written plan	Develop written plan for collaborative care coordination.	06/2021	Implement plan for collaborative care coordination.	07/2021
Manual and inconsistent data and information sharing.	Develop processes and systems for consistent data and information	08/2021	Utilize shared data and member information to streamline care coordination.	09/2021
No structured interdisciplinary team in place	Establish IDT process; 50% of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS FBDE members.	01/2022	100% of Annual IDT meetings completed by CHA-ATRIO-APD/AAA teams for LTSS FBDE members.	01/2023

Activity 2 description: Prioritize high-needs members.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Increase success rate of HRA screenings and care plan development.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
42.3% of FBDE LTSS members completed an ATRIO Health Risk Assessment (HRA) after 100% outreach to those members receiving LTSS services	75% of LTSS members complete or update their HRA.	9/2021	90% of LTSS members complete or update their HRA.	3/2022
Care Plans not currently mutually accessible	50% of LTSS care plans are updated minimally every 90 days and shared with all relevant parties	9/2021	100% of LTSS care plans are updated minimally every 90 days and shared with all relevant parties	3/2022

Activity 3 description (continue repeating until all activities included): Utilize current and new processes to improve data capture and reporting for quality and incentive metrics and other measures specific to the LTSS FBDE population to inform quality improvement and care coordination efforts.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Dashboard creation and utilization.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No quality and incentive metrics dashboard specific to the LTSS FBDE population	Create dashboard	10/2021	Utilize dashboard to inform quality improvement and care coordination efforts.	12/2021

Section 2: Discontinued Project(s) Closeout

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

A. Project short title: **Oral Health Care Coordination for Vulnerable and At-Risk Populations**

B. Project unique ID (as provided by OHA): 60

C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work

D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Based on feedback provided by OHA in its TQS 2020 Assessment, as well as feedback received from OHA regarding the 2019 -2020 PIP supporting this TQS work, and the achievement of the majority of the project's and PIP's outcomes prior to the disruption in the healthcare system due to COVID-19, CHA is redirecting its resources and efforts to focus on building data sharing and referrals between the dental and medical provider community utilizing health information technology. CHA's independently contracted oral health provider, [redacted], now provides dental services to pregnant mothers and young children at Klamath County Public Health and Head Start in addition to all local County and City schools (as permitted

based on COVID-19 restrictions). The Klamath Basin Oral Health Coalition continues the work instituted by the previous project in the community. CHA's internal workflows ensure members are assigned a dental home, and members with diabetes are actively case-managed, including established workflows whereby CHA's pharmacy staff assist members with diabetes in completing dental intake paperwork and making preventive care appointments at the time they pick-up their dental supplies.

A. Project short title: **Improve/Increase Data Collection and Analysis Capacity to Inform Member Needs**
B. Project unique ID (as provided by OHA): 32
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): OHA Project #32, Activity #2 whereby Health Equity: Data was the primary component is being closed out as complete. Activity #2 has been completed and improvements sustained. For Activity #1, CHA has reallocated internal resources toward an [redacted] case management re-implementation platform and project team in 2020 for implementation in 2021. CHA's current Case Management platform [redacted] version 3 is limited in that it is a custom-built program with restrictions to accepting [redacted] version upgrades that would include enhancements for capturing member data and multiple assessment capabilities. The new version will eliminate these challenges.

A. Project short title: **Meaningful Access to Interpretation and Translation Services**
B. Project unique ID (as provided by OHA): 62
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words): Due to the Public Health Emergency, both Rogue Community College (RCC) and Klamath Community College (KCC) moved to online learning. RCC placed its interpreter/translator program on hold which did not allow for CHA staff to be certified despite the existence of online learning. Additionally, the grant for which CHA applied to fund the proposed project with KCC was denied, therefore the project has stalled. For these reasons, CHA chose to reallocate its resources to the above activities that could be managed internally and lead to more immediate and actionable outcomes. PCPCH was included as part of this project but not scored in 2020 (revised project). The original submission scored "1" in the PCPCH domain. Based on feedback received from OHA, CHA has discontinued the previous PCPCH TQS project and initiated a new project as outlined in this 2021 submission.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).

Please find attached the following documents:

- QAPI Plan PP09007
- Utilization Measures Review, Analyzation, and Remediation PP09007.01
- Quality Management Data Use PP09005
- Quality Metrics Dashboard DP09005.01

- Health Promotion PP09006
- Screening of High Risk and Prioritized Populations for Opioid Use Disorders PP09006.01
- Quality Management Committee Charter
- 2019 QAPI Program Evaluation
- Compliance Committee Charter
- Compliance Committee Meeting Minutes (June, September, December 2020)
- 2020 Grievance Report
- 2020 Appeals Report
- 2020 Denials Report

B. OPTIONAL: Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.

Please find attached:

- Provider A&G, Member Reassignment Training Curriculum (OHA Project #32)
- Klamath Basin Oral Health Coalition Workplan (Closed OHA Project #60)
- Oral Health Brochures (Closed OHA Project #60)
- Healthy Klamath Connect (Community Information Exchange) (OHA Project #32, #33)
- CareTalk Semglee2 (2021 SHCN Diabetes Project)
- Diabetes Project Preliminary Readiness Activities Summary (2021 SHCN Diabetes Project)
- Diabetes Fishbone (2021 SHCN Diabetes Project)

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

Klamath County is located in southern central Oregon and spans nearly 6,000 square miles with a population of roughly 67,000, with approximately 30% of the population enrolled in Cascade Health Alliance. Klamath County is considered rural, and in some areas, frontier, making transportation key to accessing healthcare services. In addition to its strong partnerships with Sky Lakes Medical Center and other providers who comprise the Klamath healthcare system, CHA has established close partnerships with the two local higher education entities, Oregon Institute of Technology and Klamath Community College, to leverage limited local resources to improve the health of our community, including workforce development.

The county is predominantly white (87%) and English speaking (93%). CHA's limited English proficiency (LEP) members are estimated to be anywhere from 3% to 22% of total membership. As noted above, 2020 demographic data shows that 78.1% of CHA members prefer English (16,788 members), with the remaining 21.9% either not reporting a preferred language or indicating that they prefer Spanish, Chinese, or another language. With only 3.4% identifying they speak Spanish (731 members) and 0.1% speaking Chinese or another language (30 members) of the 21.9%, there is a gap of 18.9% of members that did not report their spoken language. Additionally, the World Population Review estimates that 7.02% of Klamath County residents speak Spanish as their first language, which is not reflected in the 3.4% who identify as speaking Spanish within CHA's data. CHA continues to monitor and address the growing cultural and linguistic needs

of its members and strives to go beyond OHA's expectations for providing language assistance (when 5% of members declare the need) to ensure that all members have equal access to information even if they did not formally declare a need for language assistance. Through continued and regular demographic data analysis, identified gaps will be addressed through multiple projects noted in this document.

CHA's Transformation and Quality Strategy reflects this direction with projects focusing on activities to better facilitate CHA's understanding of underlying social issues within our community through data collection and reporting, the need to be more culturally responsive to members and their cultural needs, and be more responsive to members with special health care needs, mental illness, and multiple chronic conditions. CHA's performance improvement projects both support and supplement the work outlined in the Transformation and Quality Strategy as well as support the full execution of CHA's Health Equity Plan.

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

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI) POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

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Printed copies are for reference only. Please refer to the electronic copy for the latest version.

Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy and procedure outlines the Quality Assurance and Performance Improvement (QAPI) Program. It includes all internal and external QAPI activities conducted by the Quality Management (QM) Department independent of and in collaboration with other departments and external providers and community stakeholders.

2 SCOPE

2.1 This policy applies to all staff that support the work of the Quality Management Committee (QMC) in assuring the quality of services provided to all members and their families.

3 POLICY STATEMENT

3.1 The Board of Directors assumes ultimate responsibility for assuring the quality of services provided to members by contracted providers, clinics and long-term care facilities is of the highest quality and consistent with available resources within the Plan.

3.2 The Board of Directors will implement changes to the Plan based on evidenced-based practices shown to have a positive impact on health outcomes and member satisfaction in consultation with its established Committee structure and recommendations from staff.

3.3 The Board of Directors ensures there are sufficient resources and support systems in place to implement the functions of the QM Department, including the implementation of the Transformation and Quality Strategy (TQS) and the QAPI Plan.

3.4 The QAPI Program is based on written policies, standards and procedures that are in accordance with evidenced-based and accepted medical practices and professional standards.

3.5 The quality of care provided to members is monitored regularly for consistency, appropriate utilization, adherence to evidence-based best practice, and member satisfaction with services provided through the Board Committee structure. The credentialing policies and procedures further reinforce the quality of care provided to members through rigorous review of provider credentials and performance.

3.6 Identified concerns are used to inform quality improvement efforts to ensure clinical efficacy, including but not limited to the TQS, PIPs, internal process improvement, provider education, feedback and improvement plans. These Quality Improvement efforts will be led by the following entities as appropriate:

3.6.1 The Chief Medical Officer

3.6.2 Quality Management department

3.6.3 Case Management department

3.6.4 Pharmacy department

3.6.5 Provider Network department

3.6.6 Claims department

3.6.7 Member Services department

3.6.8 Compliance department

4 PROCEDURE

4.1 The Board of Directors delegates to the QMC the responsibility to monitor and/or provide oversight over the following activities:

4.1.1 The Provider Credentialing and Re-Credentialing process

4.1.2 Review and approval of the TQS as presented by the QM Department and Community Advisory Council (CAC)

4.1.3 Oversight of organizational and individual clinic/provider-level performance pursuant to the Oregon Health Authority's (OHA) Quality Incentive Metrics

4.1.4 Oversight of Performance Improvement Projects (PIP)

4.1.5 Oversight and review of the quality of care provided to members based on data elements outlined within this document

4.1.6 Review of all grievances including those emanating from all subcontractors

4.1.7 Member and provider satisfaction surveys

4.2 The Board of Directors delegates to the Utilization Review (UR) Committee the responsibility to monitor and/or provide oversight over clinical efficacy, including over/under utilization of services, through the following activities in accordance with *Utilization Measures Review, Analyzation, and Remediation PP9007.01*:

4.2.1 Case review

4.2.2 Individual appeals and reconsiderations

4.2.3 Appeals, grievances, and member complaints

4.2.4 Evaluate the coordination and integration of services within the provider network, including transitions of care

4.2.5 Over and under-utilization of services provided to members, including the use of services by members with special healthcare needs. Utilization will be reviewed by categories of physical health, oral health and behavioral health at least quarterly.

4.2.6 Evaluation of case management and disease management programs provided by Cascade Health Alliance (CHA)

4.2.7 Review of second opinions

4.2.8 Provide expertise to CHA regarding clinical workflow and operations

4.2.9 Review and approval of relevant guidelines

4.3 Each department is responsible for providing monthly or quarterly reports (depending on the schedule of the report's production) to the QM Department for inclusion in the QMC meeting packet. Meeting packets are distributed to QMC members no less than one business day prior to the meeting for Committee review. The QM Department compiles the following data and/or formal reports for presentation to the QMC at regularly scheduled meetings:

4.3.1 Performance on all OHA Quality Incentive Metrics overall and by individual Providers/Clinics

4.3.2 Quarterly PIP reports as submitted to OHA

4.3.3 TQS and subsequent TQS progress reports

4.3.4 Quarterly grievance and reports as compiled by the Compliance Department, and categorized by physical health, oral health and behavioral health. In addition, this will include those grievances and complaints emanating from all subcontractors

4.3.5 Initial and Re-Credentialing files (clean as approved by the Medical Director in accordance with established Credentialing Policies; or unclean for review, discussion, and disposition by the QMC

4.3.6 Any concerns raised through scheduled reviews of licensing board actions, Office of the Inspector General (OIG) and/or System for Award Management (SAM) routine monitoring

4.3.7 Utilization review data, reports, and/or quality of care concerns as presented by the UR staff

4.4 The QM Department is responsible for the development of the TQS and subsequent TQS progress reports in collaboration with all departments.

4.4.1 The TQS follows the TQS Guidance Document published by OHA which specifies domains requiring action.

4.4.2 The TQS outlines transformation and quality strategies for the coming year based on the required domains, focuses on innovative and transformational activities and initiatives, and delineates the goals, objectives, and intended outcomes of the QAPI program.

4.4.3 Activities are chosen based on CCC's strategic plan (developed collaboratively by the Operations Council), the Community Health Improvement Plan (CHP), and recommendations from the CAC.

4.4.4 Each activity includes metrics to measure intended outcomes, targets, benchmarks, and dates against which achievement is measured.

4.4.5 Progress toward the achievement of stated goals, objectives, and outcomes is reviewed quarterly by the Operations Council.

4.5 The QM Department is responsible for initiating and facilitating PIPs based on needs identified through the review of performance data, concerns raised by members and/or the community at large, the CAC, the Community Health Assessment, the CHP, contractual requirements, or by a Board Committee.

4.5.1 PIP committees and/or work groups will include members of the QM Department, other staff as appropriate, and external community partners and stakeholders whenever possible to achieve representation from a diverse group of invested individuals and provide an objective assessment of the identified problem.

4.5.2 All PIP committees and/or work groups will establish charters to guide the group's efforts.

4.5.3 All PIPs will include a root cause analysis and/or barrier analysis to direct intervention efforts.

4.5.4 Each PIP will contain objective quality indicators to measure performance.

4.5.5 Interventions will focus on activities designed to reduce barriers to receiving appropriate or timely care, improve health outcomes, especially among disparate populations, and to sustain improvement over time.

4.5.6 PIPs are evaluated quarterly and results are reported to the QM Committee, Operations Council, and OHA.

4.5.7 PIPs will be considered "closed" if data does not demonstrate improvement despite changes made to implemented interventions.

4.6 The Case Management (CM) Department is responsible for managing and monitoring the following activities and reporting any significant concerns regarding the quality of care provided to members to the QM Department for review:

4.6.1 Members experiencing transitions in care

4.6.2 Members receiving Intensive Care Case Management (ICCM)

4.6.3 Members with Special Healthcare Needs

4.6.4 Members with Severe and Persistent Mental Illness (SPMI)

4.6.5 Distribution of Flex Funds to meet member needs otherwise not covered by CCC

4.7 The UR staff is responsible for assessing the appropriateness of care provided to members through the prior authorization process, determination of over and/or underutilization of services, and communicating concerns regarding specific providers to the Provider Network Manager and the QM Department for discussion at regularly scheduled UR Committee and/or QMC meetings.

4.8 The Provider Network Management Committee (PNMC) is responsible for managing and monitoring the provider network, ensuring appropriate and timely access to care, establishment of provider contracts, and maintenance of the Provider Directory. Concerns are brought forward to the PNMC for evaluation and action if necessary.

4.9 The Compliance Department is responsible for oversight of all subcontractors and conducts audits of subcontractors annually.

4.9.1 Annual audit reports will be submitted to the Director of QM for review.

4.9.2 Final, approved audit reports and Corrective Action Plans, if applicable, will be submitted to the QMC for review.

4.10 The QM ensures representation monthly at OHA's Quality Health Outcomes Committee (QHOC) to receive updates on health policy, incentive metrics, PIPs, and other contractual requirements related to the quality of care provided to members. Other departments are asked to participate based on the published agenda. QM staff in attendance, provide a report and distribute relevant materials to members of the Operations Council as necessary.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The QM Department will evaluate the impact and effectiveness of its systems interventions of its quality program on an annual basis.

5.2 The annual QAPI evaluation will review and report on the following activities:

5.2.1 Oversight and activities of the QMC

5.2.2 Oversight and activities of the UR Committee

5.2.3 Assessment of the quality and appropriateness of care furnished to all members, availability of services, second opinions, timely access and cultural considerations; the assessment will include a report of aggregate data indicating methods used to monitor compliance

5.2.4 Assessment of the quality and appropriateness of care furnished to members with special health care needs, including a report of aggregate data indicating the number of enrollees identified and methods used to evaluate the need for direct access to specialists

5.2.5 Demonstration of improvement in an area of poor performance in care coordination for members with SPMI, including a report of aggregate data indicating the number of members identified and methods used

5.2.6 Report on the grievance system including complaints, notice of actions, appeals and hearings, and including a report on the grievances and complaints of all subcontractors

5.2.7 Report on the monitoring and enforcement of consumer rights and protections within the Oregon Integrated and Coordinated Health Care Delivery System and demonstrating consistent responses to complaints of violations of consumer rights and protections

5.2.8 Demonstrated participation in OHA's QHOC meeting

5.2.9 Review and assessment of the following:

5.2.9.1 CHA's performance toward the goals set forth by the TQS

5.2.9.2 Overview of PIP activities

5.2.9.3 Credentialing and Re-Credentialing process

5.2.9.4 Performance on the OHA's Quality Incentive Metrics

5.2.9.5 The data management system as it pertains to the generation of validated and actionable performance data

5.2.10 Quality goals for the coming year

5.2.11 Other significant activities of the department

5.3 The annual Evaluation is reviewed by the Operations Council and Executive Approval Committee (EAC).

5.4 The EAC will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.5 Data for assessing quality of care provided to members, specific treatment requests and/or outcomes, and concerns requiring further inquiry are collected from the following sources:

5.5.1 Incentive Metric performance

5.5.2 Claims

5.5.3 Encounters

5.5.4 Risk scores

5.5.5 Referrals and Prior Authorizations

5.5.6 Peer Review, satisfaction surveys, and direct observation

5.5.7 Sanction and Monitoring activities

5.5.8 Credentialing and Re-Credentialing activities

5.5.9 Appeals, grievances and member complaints; including those of all subcontractors

5.5.10 Annual medical record reviews for provider compliance with accepted standards of medical record documentation, metric achievement

5.5.11 Concurrent review for members with special healthcare needs, medically complex cases, and/or adverse outcomes, and children with high health complexity

5.5.12 Delivery System Network report

5.5.13 Provision of services in accordance with published practice guidelines approved by CHA

5.5.14 Review of member satisfaction surveys, i.e. Consumer Assessment of Healthcare Providers and Systems (CAHPS), Mental Health Statistics Improvement Program (MHSIP), Youth Satisfaction Survey (YSS).

5.6 Metrics specific to the utilization of services across sectors as outlined in the *Utilization Measures Review, Analyzation and Remediation PP09007.01.*

5.7 The following platforms are used to obtain the data outlined above allowing for further analyzation by multiple CHA departments and provider partners:

5.7.1 [redacted]: claims/encounter-based quality measures as outlined in *QM Data Use PP9005.02*; reported weekly at the plan level and monthly to providers as outlined in *Quality Metrics Dashboard DP9001*

5.7.2 [redacted]: provides population detail via a monthly extract which provides for the identification of subpopulations based on plan/option, number of ER visits, prescriptions, demographics, gender, assigned provider, age, clinical conditions, potentially avoidable cost ranking, and probability of inpatient admit or ER visit.

5.7.3 [redacted]: monthly plan, clinic, and provider scorecards displaying risk score, risk gaps, emergency, inpatient, generic drug utilization, and chronic condition prevalence; data integrity validation conducted annually. Scorecards are used by providers to address specific members with either confirmed or suspected chronic conditions

5.7.4 [redacted]: used to visually identify the physical location of members and providers in CHA's service area to better understand how the geographic distribution of the provider network impacts members and further identify access to care concerns.

5.7.5 Collective Medical (formerly PreManage): population health data to assist in the identification and tracking of ED utilization specific cohorts as well as those with complex chronic conditions to ensure case management services are meeting the needs of the member. Reports are used daily to monitor ED and inpatient utilization.

5.7.6 Reliance eHealth Collaborative (formerly JHIE): population health data including high risk service utilization and SDOH factors, such as homelessness, food insecurity, diabetes, positive pregnancy tests, and hospital visit counts. Data is used to further stratify populations to identify gaps in care, members needing further assistance, and improvement opportunities for both internal processes as well as provider outreach.

5.7.7 [redacted]: business intelligence visualization tool used to enhance data reporting representation for internal and external provider reporting for quality metrics, including OHA incentive metrics, access measures, appeals and grievances, member demographics, and member population dispersion. Visualization reports are produced monthly for internal and external distribution through regularly scheduled Committee or internal meetings.

5.7.8 [redacted]: used to retrieve the most current claim information. Queries are developed to validate measures from other sources to produce moment-in-time information. Queries are accessed using SQL Server Reporting Services (SSRS).

5.8 Data reports are analyzed by the Quality Management Department to identify trends and/or concerns, especially as they relate to the quality of care provided to members. Concerns noted are directed to Director directly responsible for the specific service sector for investigation and remediation according to that department's policies, procedures, and processes, including review by the sector's oversight CHA Committee as noted above.

5.9 Minutes are kept of all committee meeting proceedings and are reviewed annually as part of the annual QAPI Program Evaluation.

Records Management

5.10 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 DEFINITIONS

Terms and Definitions

6.1 **Clean File (Credentialing):** A credentialing or re-credentialing file without discrepancies, red flags, or other concerns regarding the provider's ability to provide services to members.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 42 CFR 438.330

7.2 42 CFR 438.340

7.3 Health Insurance Portability and Accountability Act (HIPAA)

7.4 HIS Data Flow Diagram

7.5 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

7.6 QM Data Use.PP9005.02

7.7 Quality Metrics Dashboard.DP9001

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Approval Committee
Committee Review Dates	07/24/2019; 9/5/2019; 10/17/2019
Approval Dates	07/31/2019; 9/5/2019; 10/17/2019

10 APPENDIX

10.1 APPENDIX 1: *Utilization Measures Review, Analyzation and Remediation PP09007.01*

UTILIZATION MEASURES REVIEW, ANALYZATION, AND REMEDIATION

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 This document outlines the process for the review of utilization measures, and how the review and analyzation of the data is used to monitor the quality of care provided to CHA members.

2 SCOPE

2.1 This process applies to CHA Medical Management staff, including network providers when issues of concern are identified and require remediation.

3 PROCESS

3.1 CHA tracks a balanced measure set that includes over- and underutilization, access measures, quality measures, medical complexity, and member complaints.

3.2 All measures are reviewed monthly by the appropriate and responsible CHA departments, CHA leadership, and CHA's Quality Management Department to ensure the highest quality care is provided to CHA members.

3.2.1 Identified concerns including poor quality, overutilization or underutilization are referred to the QM department for either root cause analysis, barrier analysis, and/or development of a performance improvement project.

3.2.2 Concerns or negative trends are referred to the responsible department and/or oversight Committee, including the Utilization Review Committee, Quality Management Committee, or Provider Network Committee as applicable, for further analyzation.

3.2.3 Analysis may trigger internal process improvement, including changes to the utilization review process, and/or remediation or corrective action planning with the applicable provider.

3.3 Measures are reported monthly using the following data reference points:

3.3.1 Current performance

3.3.2 Trending year over year comparison

3.3.3 Comparison to national managed Medicaid 50th percentile and OHP 50th percentile Benchmarks.

3.3.4 Cost and units as applicable

3.3.5 Drill down by assigned PCPCH and/or facility.

3.4 The following Utilization Categories and subcategories will be reviewed and analyzed monthly to ensure clinical efficacy and inform improvement work:

3.4.1 Total Cost of Care

3.4.1.1 Physical Health

3.4.1.2 Behavioral Health

3.4.1.3 Oral Health

3.4.2 Inpatient Medical

3.4.2.1 Admissions

3.4.2.2 Inpatient days

3.4.2.3 Average length of stay (LOS)

3.4.3 Inpatient Surgical

3.4.3.1 Admissions

3.4.3.2 Inpatient days

3.4.3.3 Average LOS

3.4.4 Outpatient

3.4.4.1 Hospital

3.4.4.2 Ambulatory surgery

3.4.5 Pharmacy

3.4.6 Professional

3.4.6.1 PCP

3.4.6.2 Specialty

3.4.6.3 Behavioral Health

3.4.7 Laboratory

3.4.8 Imagine

3.4.9 ER Utilization

3.4.9.1 Total

3.4.9.2 Day and time of presentation

3.4.9.3 Acuity

3.4.9.4 Chief Complaint

3.4.9.5 Discharge Diagnosis

3.4.9.6 Assigned PCP

3.4.9.7 Medical ED utilization by members with SPMI

3.4.9.8 SUD Diagnosis (if applicable)

3.4.10 Therapies

3.5 Reports are displayed visually with data points, targets, and benchmarks clearly identified using the sources and platforms identified in Sections 5.5 and 5.6 of the *QAPI Plan PP09007*.

3.5.1 Narratives will accompany those reports that identify concerns or issues requiring further analysis.

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

QUALITY MANAGEMENT DATA USE POLICY AND PROCEDURE

In this document, CCC may be referenced in place of CCC and/or CHA.

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CCC is committed to ensuring all members are provided culturally competent care and services. We provide equal opportunity to members to obtain healthcare that recognizes their experiences, cultural diversity and needs, preferred language, and is inclusive of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex, sexual orientation, gender, gender identity, marital status, age, physical or mental disability, and veteran status.

Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy and procedure establishes an effective framework for managing Quality Management (QM) metrics performance and monitoring data.

1.2 This policy and procedure informs QM team members and other staff of the principles and processes governing the use, analysis, and storage of information related to QM performance and monitoring data.

2 SCOPE

2.1 This policy and procedure applies to all QM team members and any other staff that analyze, collect, use, or manage data related to, but not limited to, Medicaid and Medicare performance, utilization or related data.

2.2 This policy outlines the process for managing and using Medicaid performance data, including clinic data and data shared with providers.

3 POLICY STATEMENT

3.1 Quality Metrics performance data reports are generated internally by the Decision Support and Business Intelligence (BI) department according to OHA metric specifications and any additional referenced metrics specifications (i.e. CMS, HEDIS, etc.)

3.1.1 BI data analysts run reports to calculate all encounter/claims-based measures as specified by the OHA Incentive Metrics Program.

3.1.2 Benchmarks and targets for each measure are determined by the Metrics and Scoring Committee (MSC), and calculated by OHA for each CCO based utilizing the Minnesota Method.

3.1.2.1 New performance measures introduced by the MSC undergo testing and validation by the BI department, and Reliance eHealth.

3.1.3 Reliance eHealth Collaborative and [redacted] are used as secondary validation and reconciliation sources for internally generated reports.

3.1.3.1 The BI department maintains the shared data between CHA and Reliance.

3.2 QM monitors and analyzes performance data relevant to the measures included in OHA's incentive measure program. QM staff utilize the performance dashboards from BI along with the final OHA metric rolling dashboards for measure reporting, and other sources as needed.

3.3 EHR-based eCQM measures are calculated by clinics' EHRs per specifications provided by OHA and/or CMS and/or Hedis.

3.3.1 QM staff receive Electronic Clinical Quality Measure (eCQM) data from clinics via secure email. ECQM data is analyzed and compiled into plan and clinic-level dashboards collaboratively by BI and QM monthly.

3.3.2 EHR-based data is also available via our Health Information Exchange (HIE), Reliance eHealth Collaborative for all participating providers and facilities. Data includes all OHA and/or CMS measures with access to Community Health Record for specific member data search and summaries.

3.4 QM distributes both claims-based and EHR data reports to CHA leadership and providers monthly.

4 PROCEDURE

4.1 BI staff produce dashboards, trend lines, care gap lists, and other relevant reports for encounter/claims-based and EHR measures. These reports are produced on a monthly basis, and can be produced as requested utilizing the Report Request form.

4.2 The BI staff pulls data monthly and populates plan-level dashboards.

4.2.1 Clinic specific data is pulled and compiled monthly. The data is used to populate clinic specific dashboards and trend lines.

4.3 All dashboards are reviewed monthly by the Chief Medical Officer, the Director of Quality Management, and the Director of Decision Support and Business Intelligence for accuracy prior to distribution to CHA leadership and providers.

4.4 Care gap lists are produced monthly by BI staff and sent to QM staff for filtering and distribution. All relevant lists are shared with clinics monthly via secure email or more frequently as requested.

4.4.1 QM staff filter the plan-level gap lists by provider/clinic and separate into individual Excel workbooks, removing the filter function, to ensure HIPPA compliance.

4.4.2 Special data requests or gap lists cross-walking multiple measures are produced by Business Intelligence using the Report Request form and process.

4.5 Data validation for encounter/claims-based measures occurs within the QM and BI departments as well as at the clinic level through analysis and use of dashboards and gap lists. When QM becomes aware of discrepancies or is informed of discrepancies by clinics, QM and BI staff investigate utilizing claims data,

Reliance eHealth data, and the [redacted]; the OHA dashboard or other member-level claims tools may also be used for reconciliation and validation.

4.5.1 When clinics inform CHA of discrepancies, QM and BI staff utilize [redacted] to investigate claims and ensure claims include qualifying CPT and diagnosis codes per the measure specifications. If a non-qualifying code is found, QM staff contact the clinic staff to inform them of the findings.

4.6 Data validation for EHR-based eCQM measures occurs at the clinic or provider organization level through internal processes for validating EHR-based data reporting. Additionally, all EHR-based data submitted to OHA receives validation against a number of potential validity issues, such as: zero denominators, higher than expected denominators or exclusions (compared with national and/or state standards), among others.

4.6.1 QM staff utilize provider assignment lists to validate member enrollment and ensure members are only being counted once per measure.

4.6.2 QM and BI staff validate eCQMs by comparing EHR-based data month-over-month to ensure there is a positive trend and verify denominators and/or numerators are within the expected ranges.

4.6.2.1 If a discrepancy is found, QM and/or BI staff contact the respective clinic staff to discuss findings and remediation.

4.6.3 QM and BI staff may use encounter/claims data to validate visits and services rendered to validate EHR-based measures to verify denominators and/or numerators are within the expected ranges.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The Quality Management Department (QM) will review this policy and procedure for compliance with applicable state and federal law, OHA contract and guidelines, Information System Capabilities Assessment (ISCA) protocol, and OHA Metrics specifications at least annually, or as applicable. QM will forward the policy to the Executive Review Committee whenever revisions are made.

5.2 QM and Business Intelligence staff compile data reports monthly, which are shared within the department and to the Chief Medical Officer (CMO). Monthly reports include but are not limited to clinic and plan-level dashboards and plan-level trend lines.

5.3 QM is responsible for analyzing CHA and individual clinic performance on the incentive metrics and other identified indicators of performance (i.e. items being tracked in relation to Performance Improvement Projects and the Transformation and Quality Strategy (TQS) on a monthly and/or quarterly basis.

5.3.1 Incentive metrics performance are monitored against targets and benchmarks set the OHA as both a percentage of performance toward the target and trended over time as month over month and year over year.

5.3.2 Based on the analysis of performance, additional data or performance reports may be requested to further understand identified concerns or inform improvement opportunities.

Reporting

5.4 QM reports performance data monthly to provider organizations or upon request.

5.5 QM staff provides care gap lists related to the claims-based measures to each clinic monthly or upon request.

Records Management

5.6 EHR eCQM data will be maintained in the Quality Management shared drive in the appropriate measurement year sub-folder.

5.7 Encounter/Claims data reports are maintained by the BI department. All finalized dashboards are saved in the QM shared drive in the CHA Dashboard folder within the appropriate measurement year sub-folder.

5.8 Data extracts sent to Reliance and [redacted] as well as data reports received from Reliance and [redacted] are maintained by the BI department.

5.9 Care Gap lists are created by the BI department and emailed to the QM department for separation and distribution. The gap lists are saved in the QM shared drive in the Clinic Engagement folder within the appropriate measurement year sub-folder.

6 DEFINITIONS

Terms and Definitions

6.1 **Electronic Clinical Quality Measure (eCQM):** An EHR-based clinical care quality report included in OHA quality incentive metric program typically following the specifications outlined by CMS.

6.2 **Information System Capabilities Assessment (ISCA):** A bi-annual review conducted by OHA's External Quality Review Organization (EQRO), which involves assessment of all information systems within the CCO, including data systems and use.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 42 Code of Federal Regulations (CFR) §438.358

7.2 42 Code of Federal Regulations (CFR) §438.334(b)

7.3 Health Insurance Portability and Accountability Act (HIPAA)

7.4 OHA External Quality Review Organization (EQRO) Information System Capabilities Assessment (ISCA)

7.5 Oregon Health Authority (OHA) Quality Incentive Metrics Program

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing qualitymanagement@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Executive Review Committee
Committee Review Dates	10/12/2018
Approval Dates	10/15/2018

10 APPENDIX

Quality Metrics Dashboard Process DP09005.01

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

QUALITY METRICS DASHBOARD PROCESS

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 To provide an update on quality metrics performance to internal leadership and clinics.

2 SCOPE

2.1 This process applies to the Quality Management department.

3 PROCESS

3.1 Data analysts in the Decision Support and Business Intelligence department run the internal reports for metric performance and refresh the dashboard built in [redacted].

3.2 Dashboards are filtered for CHA and every clinic and saved as draft pdfs.

3.3 The CMO, QM Director, and BI Director meet the first Tuesday of every month to review the draft dashboards and make any necessary edits.

3.4 Once approved, the clinic-level and CHA Quality Metrics dashboards are finalized and shared with the clinics via the monthly Metrics meeting.

3.5 The Quality Metrics Dashboards are also distributed at the Quality Management Committee meeting, Behavioral Health Providers meeting, and to Oral Health Providers via email.

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HEALTH PROMOTION AND PREVENTION

POLICY AND PROCEDURE

In this document, CCC is referenced in place of CCC and CHA.

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Terms not defined in the DEFINITIONS section of this document may be found in the Glossary.

1 PURPOSE

1.1 This policy establishes CCC's expectations of providers in promoting and performing health screenings to aid in the prevention of chronic illness.

2 SCOPE

2.1 This policy applies to all providers, including physical, behavioral and oral health care providers.

3 POLICY STATEMENT

3.1 CCC expects providers to actively promote all health screening methodologies which have received a Grade A or B recommendation by the United States Preventive Services Task Force to all members and their families.

3.2 For those providers serving pediatric members, CCC expects the active promotion of screenings recommended by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition; 2017).

4 PROCEDURE

4.1 Providers will establish internal, individual clinic processes and workflows to ensure that the recommended health screenings are performed as appropriate for each member.

4.2 The Quality Management Department will establish an annual plan for Health Promotion and Prevention activities as part of its annual strategic planning process.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 CCC's Quality Management Department will monitor providers' use of health screenings through the monitoring and review of outcome data, member satisfaction, and service utilization.

5.2 CCC's Quality Management Committee reviews performance data on a quarterly basis at minimum.

5.3 The Executive Approval Committee will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

5.4 This policy aligns with the expectations set forth in CCC's contract with the Oregon Health Authority to provide services as a Health Plan.

Reporting

5.5 The Quality Management Committee's recommendations as they pertain to Health Promotion and Prevention will be reported in the annual Quality Assurance and Performance Improvement (QAPI) Evaluation.

5.6 The activities of the Quality Management Department as they pertain to Health Promotion and Prevention within the broader community as well as member specific efforts will be reported in the annual QAPI Evaluation.

Records Management

5.7 Team Members must maintain all records relevant to administering this policy and procedure in the recognized record management system.

6 DEFINITIONS

6.1 There are no terms or definitions to define for the administration of this policy.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 United States Preventive Services Task Force: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

7.2 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (4th Edition; 2017): https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Introduction.pdf

7.3 Health Insurance Portability and Accountability Act (HIPAA)

7.4 Oregon Health Authority (OHA): Coordinated Care Organizations (CCO)

8 FEEDBACK

8.1 Team Members may provide feedback about this document by emailing policyfeedback@cascadecomp.com.

9 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	Quality Management Committee
Committee Review Dates	08/01/2019,
Approval Dates	08/01/2019,

10 Appendices

10.1 *Screening of High Risk and Prioritized Populations for Opioid Use Disorders PP09006.01*

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

Screening of High Risk and Prioritized Populations for Opioid Use Disorders

In this document, CCC is referenced in place of CCC and CHA.

1 PURPOSE

1.1 The purpose of this document is to outline the expectations for the screening of high risk and prioritized populations for Opioid Use Disorders to facilitate prevention and treatment services.

2 SCOPE

2.1 This applies to all CHA members and contracted providers.

3 Process

3.1 High Risk and Prioritized Populations are those populations considered at high risk for severe health outcomes, including overdose and death:

- 3.1.1 Pregnant women
- 3.1.2 Veterans and their families
- 3.1.3 Women with children
- 3.1.4 Unpaid caregivers
- 3.1.5 Families
- 3.1.6 Children ages birth through five years
- 3.1.7 Children in Foster Care or under the custody of DHS
- 3.1.8 Individuals at the risk of first episode of psychosis
- 3.1.9 IV drug users
- 3.1.10 Individuals with HIV/AIDS or tuberculosis
- 3.1.11 Individuals with Intellectual and/or Developmental Disabilities (I/DD)
- 3.1.12 Individuals being discharged from residential, acute care, and other institutional settings
- 3.1.13 Children with serious emotional disturbance
- 3.1.14 Members with Opioid Use Disorder
- 3.1.15 Individuals requiring Medication Assisted Treatment
- 3.1.16 Members eligible for ICC Services

3.2 High Risk and Prioritized Populations must be screened for Opioid Use Disorders under the following circumstances to provide prevention services, early detection, brief intervention and referral to behavioral health services:

- 3.2.1 At initial contact or during a routine physical exam
- 3.2.2 At an initial prenatal exam

3.2.3 When the member shows evidence of SUD or abuse

3.2.4 When the member over-utilizes covered services, and/or

3.2.5 When a member exhibits a reassessment trigger for Intensive Care Coordination

3.3 Pregnant members receiving prenatal and post-partum care will be screened using validated tools for behavioral health needs at least once during pregnancy and once during the post-partum period.

3.4 Members with positive screens will be referred for further preventive or treatment services as indicated by the outcome of the screening as deemed appropriate by the provider conducting the screening.

3.4.1 Intake and access timeliness for pregnant women and other priority populations shall be in accordance with 410-141-3220.20

4 Related Documents and Legislation

4.1 Oregon Administrative Rule 410-141-3220

4.2 Oregon Health Authority Contract #161756

IV. RESPONSIBILITIES

Responsibilities of QMC include, but are not limited, to the following:

- Help ensure quality initiatives, objectives and goals are being successfully addressed.
- Identify and review quality management issues brought forward by providers, stakeholders or CHA staff.
- Monitor progress on assigned action items, tasks, and projects.

V. MEETINGS

1. Schedule – In order to ensure timely credentialing of providers, QMC meets eight months per year and no less than four times annually.

2. Special Meetings – additional meetings may be called by the QMC Chairperson, CMO, or Director of Quality Management, if necessary, to conduct the business or to address critical issues in a timely manner.

3. Electronic Meeting/Voting – when meeting in person is not possible or advised, the Director of Quality Management will send members emergent items via electronic mail to which their response will be considered their "vote" for purposes of continuing the Committee's work in such situations. Conference calls may also be held when meeting in person is not possible or advised.

4. Cancellation – the CMO or Director of Quality Management may cancel a regularly scheduled meeting if deemed appropriate or if the majority of members are not able to attend the meeting. Cancellation notices will be sent to committee membership via email at least one week prior to meeting.

5. Reminders – meeting reminders will be sent to QMC membership via email the Monday prior to each meeting.

6. Guests – the Chairperson of the QMC, CMO or Director of Quality Management is permitted to invite guests knowledgeable on subjects and issues to any regularly scheduled meeting to support educational aspects and provide expertise when necessary. QMC members are eligible to recommend potential guests at any scheduled meeting.

7. Agendas – meeting agendas shall be developed by the Director of Quality Management or designee. Agendas and meeting materials will be shared with QMC members prior to each meeting for member review.

8. Minutes – meeting minutes shall be developed by the Quality Management Administrative Assistant or other CHA staff as designated by the Director of Quality Management. Minutes of each meeting shall be submitted to the members of the Committee for review prior to

each subsequent meeting. Meeting minutes shall be presented at the next regularly scheduled meeting for approval.

9. Decision Making – a majority of members of the QMC will constitute a quorum. A decision will be approved by simple majority of members in attendance.

10. Confidentiality – QMC members shall be aware of CHA's need for member confidentiality and discretion related to CCO-specific business. The QMC may at times review member-specific data. When possible, CHA will attempt to de-identify member or provider specific information. QMC members shall not report member, provider, or CCO specific information or opinions expressed in meetings outside the Committee, other than to follow-up on a member's clinic-specific business. Certain data and information presented to this Committee are protected by ORS 41.675.

11. Conflict of Interest – it is recognized that QMC members and the organization they represent may be personally, professionally, or financially impacted by the decisions of the Committee. Transparency in sharing conflicts of interest is essential to ensure the integrity of the QMC decision making. QMC members are required to disclose any potential conflicts of interest pursuant to CHA OI 1-05 *Conflict of Interest.*

VI. MEMBERSHIP

1. Composition – the membership of the Committee shall be comprised of (but not limited to) the following:

   At least five, but no more than fifteen, External Parties:
   - Contracted Providers, including at minimum one physical health care provider, one behavioral health care provider, and one dental provider
   - Partner Organization Administration Staff, including Behavioral Health and Dental

   Required CHA staff:
   - Chief Medical Officer (CMO)
   - Director of Quality Management
   - Quality Management staff
   - Additional CHA staff as deemed appropriate

   Additions to External Party membership requires appointment by CHA Board of Director. CHA staff membership must be deemed appropriate by the Director of Quality Management, CMO, or CEO.

2. Term – members shall serve at least one year, with membership reviewed annually.

3. Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of chairperson is two years.

4. Vice Chairperson – will be selected and confirmed by CHA Board of Directors with recommendations from Committee membership, CEO, CMO, or Director of Quality Management. The term of vice chairperson is two years.

5. Dismissal – members who are absent, without reasonable cause, from at least 50% of regularly scheduled meetings within a calendar year may be excused from the Committee.

6. Vacancies – members of the QMC will be appointed or approved by CHA Board of Directors. When positions are vacated, the QMC, CMO, or Director of Quality Management may either recommend or solicit participation from contracted providers or clinic administration staff.

7. Member Role – members shall:

    - Review and be accountable for their role in the group's efforts.
    - Participate in exercises and be familiar with how the activities of the QMC are relevant to CHA, quality management, and CHA members.
    - Attend QMC meetings consistently or advise of an absence in a timely manner.

VII. ORGANIZATIONAL STRUCTURE

The QMC is an advisory committee to the CHA Board of Directors and is sponsored by CHA. This is a standing and ongoing committee. At least one member of the CHA Board of Directors shall also serve on the QMC.

VIII. SUB COMMITTEES / WORK GROUPS

QMC will charter subcommittees or project teams as needed upon approval from Chief Medical Officer or Director of Quality Management.

IX. CHARTER REVIEW

This QMC charter shall be reviewed annually. Material revisions to the Charter shall be presented to the Board of Directors for approval.

X. CHARTER APPROVAL

Date Chartered: May 3, 2018
Date Approved: August 2, 2018

QUALITY MANAGEMENT COMMITTEE
CHARTER

Date Revised: July 23, 2019
Date Revised: March 23, 2020
Date Approved: April 2, 2020

Quality Management Program Evaluation

2019

Prepared by:

Susan L. Boldt, MS CPHQ

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Executive Summary

This report serves as the annual evaluation of CHA's Quality Management program, outlining quality activities that occurred in 2019 and goals for 2020.

2019 was a challenging year for the Quality Management (QM) Department. Throughout the course of the year, QM was a key contributor to the RFA process to secure a 5-year contract under CCO 2.0. Post-RFA, QM actively contributed to both remediation and readiness efforts. Additionally, QM took on overall responsibility for Health-Related Services as well as Health Equity. These efforts had the unintended consequence of diverting the department's focus from its Performance Improvement Projects and metrics performance.

This shift was reflected in CHA's final metrics performance. CHA met 11 (10 plus PCPCH) of the Oregon Health Authority's (OHA) 17 incentive metrics compared to 14 in 2018, and 2 of the 4 challenge pool measures. Due to CHA's performance in 2018, performance targets for 2019 were set considerably higher than in 2018, and in some cases at benchmark. Also of note was an increase in membership which increased the denominator for several measures. A root cause analysis of the underperformance was conducted by a multidisciplinary team to identify the root causes and make recommendations for improvement going forward. Details of the root cause analysis are contained within this document.

Two positions were added to the department during 2019, both filled by current department employees: Quality Management Analyst (focus on the Stars program) and Health Equity Manager. The vacant Quality Management Analyst (focus on OHA's Incentive Metric program) was filled by an internal transfer from Business Intelligence. Finally, an Administrative Assistant (focus on Provider Credentialing) was added in late summer. The Health Equity Manager left the company in October 2019. Those job duties were covered by the Director for the remaining of the year.

Quality Management Department and Committee Structure

The Quality Management (QM) Department consists of five team members responsible for executing CHA's Quality Strategy for improving the health outcomes of CHA members through the Triple Aim of better care and better health at a lower cost.

Quality Management Department Team:

David Shute, MD Chief Medical Officer/Medical Director

Susan Boldt, MS CPHQ Director of Quality Management

Cord VanRiper, Quality Management Analyst (January 2019 – July 2019); Health Equity Manager (July 2019 – October 2019)

Patricia Pahl, Quality Management Specialist (January 2019 – May 2019); Quality Management Analyst (May 2019 – December 2019)

Cally McCool, Quality Management Analyst (September 2019 – December 2019)

Shelley Emary, Quality Management Administrative Assistant (August 2019 – December 2019)

The following three Board of Directors' commissioned Committees inform the activities of the Quality Management department:

The **Quality Management Committee** (QMC) is a Board Committee tasked with oversight, development, and approval of all activities related to CHA's quality strategy (including the Transformation and Quality Strategy – TQS), provider engagement, quality metrics, performance improvement projects, and the credentialing of CHA's network of providers. The Committee utilizes information from grievances as part of its peer review function during the credentialing process. The QMC is composed of local healthcare providers, including representatives from oral and behavioral healthcare, and meets no less than 8 times per year. Activities of the Department are reported to CHA's Board of Directors by the Medical Director and CEO.

The **Utilization Review Committee** (URC) oversees the activities of the Utilization Review (UR) and Case Management (CM) Departments, and is composed of local specialists, primary care, and BH providers. The URC is responsible for monitoring over/under utilization of clinical services, including hospital readmissions. Members lend their expertise regarding second opinions, reconsiderations, appeals, and clinical guidelines. While not directly accountable to the Quality Management department, the Committee plays a vital role in ensuring the quality of care provided to CHA members. Activities of the UR/CM Departments are reported to CHA's Board of Directors by the Medical Director and CEO.

The **Compliance Committee** oversees all compliance activities, including performing risk framing and assessment to reduce regulatory, privacy and compliance risks facing the organization. The Committee also reviews appeals and grievances assessing for patterns posing significant risk to CHA and makes recommendations for corrective action as necessary. Activities of the Compliance Committee are reported to CHA's Board of Directors by the Chief Operations Officer and CEO.

Internally, two Committees inform Quality Management activities: Provider Network and Member Experience. The Provider Network Committee reviews provider requests for inclusion in CHA's network via contract and/or credentialing. Additionally, the Committee reviews appeals and grievances assessing for patterns requiring immediate intervention by the Provider Network Manager. The Member Experience Committee assists in the identification of outreach and improvement opportunities to improve members' experience with the health plan, including the translation of member materials and the provision of interpreter services.

All CHA Departments report to senior leadership through the Operations Council which serves as the internal Quality Improvement Committee. The Operations Council meets monthly reviewing tasks and initiatives from all CHA departments, including enterprise-wide projects as reported by the CEO and Chief Operations Officer.

In addition to participating in Healthy Klamath Coalition, members of the Quality Management team participate in the following community and/or State committees, coalitions, or collaboratives:

Medical Director:

Klamath County Medical Society Board of Directors

Director of Quality Management:

State Health Improvement Plan Adversity, Trauma, and Toxic Stress Sub Committee

Quality Management Analysts:

Klamath Basin Oral Health Coalition

Blue Zones Leadership and Steering Committee

Blue Zones Tobacco Policy Committee

Klamath Opioid Taskforce

Klamath Nutrition Hub through the Moore Institute

Klamath Lake Counties Council on Aging

Older Stakeholder Meeting

Transformation and Quality Strategy (TQS)

In accordance with its contract with the Oregon Health Authority (OHA), CHA executed a Transformation and Quality Strategy targeting those areas identified by OHA as essential to the transformation of healthcare in Oregon. The Strategy is a collaborative effort among all CHA departments, including the Community Advisory Council, with activities designed to effect transformation and integration of the community's healthcare system. A new format for this report was issued by OHA in March 2018, and further refined in 2019 allowing for multiple components to be included in the same project. The report is submitted two times per year, mid-March, and a progress report in September.

Overall feedback from OHA on 2019's TQS was that it did not contain sufficient detail to adequately describe the projects, or for OHA to accurately ascertain the scope of several projects. Due to organization efforts being focused on the RFA, remediation and readiness when OHA's assessment was received, a decision was made to not make revisions and resubmit. OHA did not require CCOs to submit a mid-year progress report due to CCO efforts being focused on 2020 contract procurement.

The most recent TQS Progress Report and OHA's Assessment are both available upon request for more information.

Projects of note in 2019 included (green denotes projects completed):

Transformative Area	Activity
Access	See Health Equity; CLAS Standards and Provider Network
SDOH	See CLAS Standards and Provider Network; Health Equity
CLAS Standards and Provider Network	Translation and alternative formats of member materials: **increase the amount and type of materials immediately available to members in different languages and alternative formats (project specific to Spanish translation)**; increase the amount and type of materials immediately available to members in alternative formats (project specific to large print and audio); create and execute a referral process for members to culturally and linguistically appropriate community resources and services; provide training on multiple aspects of SDOH-E for CHA staff team to further its understanding of the challenges faced by our members.
Special Health Care Needs	Pediatric medical complexity and management of chronic, complex conditions: identification and management of children with high medical complexity, collaboration with community partners and providers from behavioral, physical, and oral health based on the member's immediate needs; **intervention strategies and pilot projects for improving oral healthcare in members with diabetes developed in collaboration with the Oral Health Coalition and area providers; improve the rate of oral health assessment and preventive services received by members with a diagnosis of diabetes**.

Utilization Review	Emergency department utilization: Case/Care Management Best Practices Learning Collaborative; creation and execution of a complex/chronic disease "system of care" for the Klamath County community; **Collective Medical access implemented among providers, and sustained use** by all local clinics/providers, including behavioral health and oral health providers.
Health Information Technology	See Health Equity; Utilization Review
Grievance and Appeal System	Member reassignment: member/provider reassignment process will be developed to integrate and systematize the process of reassigning members, so reassignments are easily tracked, and all parties are aware of changes in a timely and consistent manner.
Value-Based Payment Models	Payment methodology: **measure each clinic's and/or providers' performance against the improvement target set by OHA for each incentive measure. Clinics that meet or exceed the target earn incentive payments**; integrate member demographic and SDOH data into clinic performance data for in-depth analysis and assist in identifying opportunities for improvement with greatest impact on member health outcomes; support clinics and/or providers in their efforts to either increase tier levels or become PCPCH.
Severe and Persistent Mental Illness	See Utilization Review
Patient-Centered Primary Care Home (PCPCH)	See Value Based Payment Models
Integration of Care	See Special Health Care Needs; Health Equity
Health Equity and Data	Improve/increase data collection and analysis capacity to inform member needs: integrate SDOH data into current equity dashboard to guide equity improvements to improve member health outcomes; improve accuracy of data collection to better capture all member needs; **member education regarding establishing care at the onset of coverage; implementation and execution of Access Mobile as part of a comprehensive digital member engagement strategy**.

Performance Improvement Projects (PIPs)

CHA has sustained community and provider involvement in each of its Performance Improvement Projects. Four areas were noted as needing targeted interventions to facilitate performance improvement in 2019. Improvement strategies were represented in the formal performance improvement projects noted below as well as internal systemic improvement projects contained within the Transformation and Quality Strategy (as noted above).

2019 Performance Improvement Projects
Emergency Department Utilization
Oral Health
Statewide Chronic Opioid Use
Oregon Pediatric Improvement Partnership *Focus Study and Technical Assistance*

Two projects were closed out in 2019: Tobacco Cessation and the Statewide Chronic Opioid Use project. The Tobacco Cessation project was a 2-year project to establish the internal infrastructure to successfully meet the incentive metric and provide assistance to our provider network in establishing and sustaining assessment protocols for tobacco use. Those objectives having been met, and continued Community-wide efforts focusing on tobacco retail licensing (TRL) and cigarette butt disposal, the decision was made to close the project. CHA continues to offer Freedom From Smoking classes through its Pharmacy department, as well as continued partnership with Blue Zones and Klamath County Public Health to sponsor tobacco-free zones and events.

CHA continued its partnership with the Southern Oregon Collaborative, initially formed to pool resources to obtain a broader impact toward the State-wide Opioid PIP. Members of this CCO collaborative included Primary Health, Umpqua Health Alliance, Advanced Health, Care Oregon, Jackson Care Connect, AllCare, and Cascade Health Alliance. CHA provided financial resources toward the Southern Oregon media campaign and creation of www.staysafeoregon.com as well as administrative resources and work product on several sub-committees. The partnership did not produce the desired media impact hoped for in the Klamath Community. With OHA changing its focus in 2020 from Chronic Opioid Use to Acute Opioid Prescribing, the Quality Management department made the decision to discontinue participation in the Collaborative going forward into 2020, instead collaborating with Lake County and participating in the High Desert Rural Opioid Partnership.

CHA continued its efforts toward reducing Emergency Department Utilization among its entire population. While CHA did not achieve its 2019 targets for overall ED utilization or ED utilization among the SPMI population, the community partnership and provider involvement in the effort was sustained through 2019. Based on data, the group agreed to narrow its focus to those presenting at the Emergency Department with substance use diagnoses and/or in need of substance use disorder (SUD) treatment. Workflows for both local SUD providers for after-

hours assessment and entry into treatment were collaboratively created, including specific instructions for Release of Information completion to expedite the exchange of information between provider types. The project will be sunset in Q1 of 2020 but the work will continue through the Behavioral Health Providers monthly meeting.

PIP Reports are available upon request for more details on each Performance Improvement Project.

CHA also participated in two Technical Assistance opportunities offered by OHA that were aimed at gauging CCO's readiness for two new proposed metrics: Obesity Prevention and Treatment Multisector Intervention and Health Equity Meaningful Language Access. As a result of these two "projects", the team determined that CHA will have a considerable amount of infrastructure to build to support the two metrics should they be adopted by OHA in the future. Both measures require CCO attestation to individual items contained in the measure specifications, and each contains a three-year phase-in. To meet the Obesity measure, CHA would have to build the capacity for a pediatric diabetes prevention program. For Meaningful Language Access, CHA would have to build the capacity internally to collect the required data on the utilization of interpreter and translation services, or contract with a different Language Line capable of providing the required data as its current provider is unable to do so.

Provider Credentialing

The Quality Management Administrative Assistant serves as CHA's Credentialing Specialist. CHA processes all credentialing files within 90 days of receipt of a *complete* file in accordance with Oregon Administrative Rule. Files are considered complete when all required documents are received. According to federal law, applications must be complete and approved by either the Medical Director (clean files) or the Quality Management Committee (unclean files) within 180 days of the provider's signature on the application, attestation, Attachment A, and Release of Information. If not, the application is rejected, and the provider must begin the process anew.

Credentialing applications meeting the standards contained in Credentialing Policy PP09002 as "clean", are presented before the Medical Director by the Director of Quality Management for review and final approval. The QMC is notified at its regularly scheduled meetings of all "clean" files approved by the Medical Director. Files deemed "unclean" upon the Quality Management Administrative Assistant's initial review (insufficient CME/CE, License or Board sanctions, missing peer references, malpractice and/or criminal history) are reviewed and confirmed as "unclean" by the Director of Quality Management and Medical Director and then forwarded to the Quality Management Committee for review, discussion, and action. The QMC serves as the peer review body for this purpose. Complete, clean files are forwarded to the Director of Quality Management for review.

CHA has Delegation Agreements with four BH providers outlining the expectations for credentialing their clinical staff and requiring the providers to be compliant with CHA's credentialing policies. In 2018, CHA's auditing process focused on monitoring providers' development of credentialing policies and processes. In 2019, the process was revised to reflect monitoring of how the providers were executing and consistently following their documented processes. In both years, items were weighted based on their potential to have a direct impact on member rights and safety. Of the four providers, one (1) was deemed substantially compliant (91.5%), two (2) were partially compliant (76%), and one (1) was considered non-compliant (70.4%). Technical assistance was offered to each provider as they created and implemented their corrective action plans. All corrective action plans were completed timely per CHA's request.

CHA's credentialing policies are reviewed annually. However, revisions can be and are made throughout the year based on recommendations and action taken by the Quality Management Committee.

Oregon Health Authority Incentive Metrics

CHA achieved 60% of the available Quality Pool funds by meeting or exceeding the target on 11 incentivized metrics (10 metrics plus PCPCH) out of 17 of the OHA's Incentive Metrics (an additional 2 measures were reporting only, of which CHA met the required reporting threshold). CHA also met 2 of the 4 Challenge Pool measures which brought the allocation up to 85% of the available dollars. This performance was a significant decrease over 2018's performance (achievement of 100% of the available quality pool dollars through achievement of 14 of 17 measures, as well as meeting the target on all four challenge pool measures). Due to 2019's underperformance, a robust root cause analysis was performed, and is detailed in the next section.

Below is a summary of metrics achievement in 2019:

2019 Oregon Health Authority Incentive Metrics
Adolescent Well Care (youth 12 – 18 years of age)
Childhood Immunization Status (Immunizations *prior* to the child's second birthday)
Colorectal Cancer Screening
Dental Sealants (youth ages 6-9; 10-14)
Development Screenings (prior to 36 months of age)**
Effective Contraceptive Use
Health Assessments within 60 days for Children in DHS Custody**
Timeliness of Postpartum Care**
Depression Screening and Follow-Up*
Oral Health Evaluation for Members with Diabetes
Weight Assessment and Counseling
SBIRT*
Smoking Prevalence
Diabetes Poor HbA1c Control
Controlling Hypertension
Person Centered Primary Care Home
CAHPS Survey Results – Access to Care (composite of both Child and Adult Scores)
Emergency Department Utilization
Emergency Department Utilization by Members with a Mental Illness

Red indicates measure's target was not met; Green indicates measure's target was met

*Indicates measure was reporting only

**Indicates measure was a challenge pool measure

In comparison to CCO performance state-wide, CHA and three other CCOs (Health Share of Oregon, Trillium, and Inter Community Health Network) met 60% of their available quality pool funds; six CCOs earned 80%; and five CCOs earned 100%.

As seen in the chart below, despite overall achievement being lower in 2019 than 2018 (i.e. achieving 60% of the available quality pool funds vs. 100%), CHA's 2019 performance was better than 2018's by an average of 2.9% on four claims measures (adolescent well care, dental sealants, developmental screenings, and oral health evaluations in members with diabetes); an average of 5.7% on cigarette smoking prevalence and hypertension; 17% on postpartum care; and 9.1% on PCPCH.

Metric	2018 Rate	2019 Rate	2019 Target
Adolescent Well Care	42.3	47.5	44.6
Ambulatory Care - ED Utilization (per 1,000 MM)**	45.7	46.2	44.8
Assessments for Children in DHS Custody	91.5	86.5	90
CAHPS	81.5	76.4	83.5
Childhood Immunization Status	82.4	79.3	81.9
Cigarette Smoking Prevalence**	28.3	20.7	27.3
Colorectal Cancer Screening	61.3	51.8	61.1
Dental Sealants	27.3	30	26.8
Depression Screening*	39.3	52.3	N/A
Developmental Screenings	79.4	82.3	80
Diabetes HbA1c Poor Control**	27.4	28.3	25.4
Disparity Measure: ED Utilization Among Members with Mental Illness (per 1,000 MM)**	93.4	98	90.6
Effective Contraceptive Use	51.8	49.4	53.9
Hypertension	59	64.1	61
Oral Health Evaluation for Diabetes	21.3	27.4	24.3
PCPCH	66.2	77.1	N/A
Postpartum Care	73	86.3	69.3
SBIRT*	N/A	93.2	N/A
Weight Assessment and Counseling in Children and Adolescents	54.8	53.7	32.7

*Reporting only **Lower is better

Improved performance over 2018 Poor performance over 2018 Target met in 2019

CHA's payment methodology for the incentivized quality pool dollars is reviewed on an annual basis by the Quality Management department. Recommendations are sent to senior leadership for review with the final methodology approved by the Board of Directors. Considerations for payment may change dependent on metric achievement between multiple providers types (for example, Health Assessments for Children in DHS Custody is a measure with three components: physical health, mental health, and oral health assessments), contractual requirements for

performance, as well as a provider's ability to produce data reports on EHR measures for which CHA does not have access to the provider's data.

Final provider allocation is determined based on provider performance on the final date for submission of all 2019 claims, March 31, 2020. As part of the quality control process, the logic for each calculation associated with the payment allocation is reviewed in detail against the measure specifications to ensure consistency and accuracy and approved by the Quality Department and Business Intelligence before proceeding with the calculations. The allocation is then generated in a combined effort by a Quality Management Analyst and Health Informatics Database Analyst (Business Intelligence department) to ensure accuracy. The final product is reviewed and approved by the Director of Decision Support and Business Intelligence, Director of Quality Management, and Chief Medical Officer before being presented to senior leadership and the CEO for review and approval, and presented to the Board of Directors.

2019 Oregon Health Authority Incentive Metric Performance Root Cause Analysis

The Business Intelligence and Quality Management departments conducted an in-depth root cause analysis to identify the key internal factors impacting 2019's under-performance. Provider input regarding key external factors was gathered during sessions with key partners. This combined effort, the identified internal and external root causes, and action plans for remediation are summarized below. The full report is available upon request.

Primary Internal Root Causes – Key Findings (in order of impact)**:**

1. Task/Process Factors
    - Lack of documented processes
2. Staff Performance Factors
    - Inattention to detail, distraction, or workload
    - Staff knowledge deficit or competency
3. Management/Supervisor/Workforce Factors
    - Staff training
    - Failure to correct a known problem

Analysis of Internal Factors:

Multiple Task/Process factors were identified as being key contributors to 2019's poor performance. The Quality Management and Business Intelligence departments lacked a strong infrastructure of documented business processes to guide their operations. Important tasks and processes (i.e. data storage, validation, registry development, dashboard creation, quality control, individual metric tracking) either did not exist or were not documented. Additionally, many processes were manual in nature which led to data entry errors. The last-minute production of reports further compounded data entry errors as data validation, editing, and/or proof-reading did not occur consistently prior to distribution. Knowledge of key processes and tasks was held by one individual within the company. When the individual left the company, the knowledge of those processes and tasks was lost due to the lack of or inadequate documentation.

Several staff performance factors were observed. As noted above, the manual process for dashboard and trendline creation allowed for data entry errors. These errors were further compounded by last-minute report production which did not allow for a consistent quality control process to ensure accuracy prior to distribution. The focus on CCO 2.0 RFA, remediation and readiness diluted the amount of attention paid to data analysis and concentration on metrics performance. Complacency in the form of "we got this" due to stellar performance in 2018 was also a contributing factor.

In-depth knowledge of each metric is a key component to successful performance, and without which, leads to a faulty strategy for metric achievement. Misinterpretation of measures is a common occurrence, as is differing interpretations of measure specifications between staff,

necessitating frequent communication with OHA for clarification. While QM frequently asked questions of OHA regarding measure specifications, they did not seek internal expertise from Business Intelligence more timely when questioning measure performance.

Also of note is that CHA received incorrect guidance from OHA on the data received from Alert for the Childhood Immunization measure. This was discovered during the root cause analysis process concurrent with the validation of 2019 data through the retrospective construction of all measure data reports.

CHA relied on data reports from one external vendor to track its metrics performance but lacked an internal validation process for the data provided by this outside source. The platform, [redacted] gave notice in December 2019 that it intended to sever its contract with CHA at the end of January 2020. This time frame was in the beginning of the 2019 performance validation and chart scrub process. In response, Business Intelligence (BI) sought support from another external vendor, Reliance eHealth. During the transition, CHA built performance reports for all claims-based measures to assist in the validation of Reliance's data. Through this process, BI discovered faulty logic in [redacted] reporting resulting in CHA overstating its 2019 performance to its providers and external stakeholders on several measures throughout the course of the year. The unintended consequence to over-reporting performance is a decrease in efforts toward metric achievement on measures already met or tracking to meet by the end of the measurement year.

2019 also saw changes to the platform its Medicare Advantage line of business, Atrio, utilizes to process claims. Incomplete claims ingestion for dual eligible members was not discovered for approximately six months post-transition. As a result, the claims-based measures were reported inaccurately internally and externally for the latter half of 2019. The point at which the issue was identified did not allow time for all claims to be processed and validated prior to the last date to submit claims to OHA for the 2019 measurement year. The consequence to not submitting all claims is not only under-reporting performance for 2019 but also potentially the establishment of either lower or mis-performance targets (depending on the metric) for 2020, making 2020 achievement more challenging.

Internal Improvement Recommendations:

The following improvement opportunities were recommended by the root cause analysis team:

1. Build all metric performance reports internally, using only external platforms for secondary and tertiary validation
2. Standardize and document all QM and BI processes.
3. Ensure cross-training and validation process for all QM and BI functions.
4. Monthly QM and BI meetings at the Director/CMO level to review and scrutinize data reports to identify potential inaccuracies and identify trends early.

Primary External Root Causes (in order of impact)**:**

1. Communication/IT Factors

- Availability of information

2. Task/Process Factors
3. Staff Performance Factors
    - Fatigue, inattention, distraction, or workload

Analysis of External Factors:

Several themes were consistently noted by providers: lack of timely data (and data that was provided was "deceiving"), lack of strategic planning, and attention focused elsewhere during the measurement year.

Providers consistently noted that performance data was not available more timely, particularly earlier in the measurement year so that corrective action could be taken in the first six months of the year, eliminating or lessening the end of year push. Taking a retrospective look at the data that was provided, providers noted that it was "deceiving" and "disappointing" in that it was incorrect, painting a picture of much better performance than was actually the case. Providers assumed that because they were performing well and trending toward meeting the measures, they would continue along that trajectory, and so shifted their focus to other projects (for example, to the completion of the Collaborative Health Center). Had providers been aware earlier that their performance was not trending toward meeting the targets, they stated they would have intensified their efforts toward achievement.

Frustration was also expressed that eligibility was not better tracked and/or accounted for in CHA's data reporting.

Of concern was the "whack a mole" syndrome. As a healthcare community, we tend to focus on individual measures in the moment, but this does not create improvements that are sustainable into the future. Managing performance in this way does not help create the workflows or processes necessary to sustain improvements into the future. Some providers also noted that they expended less effort on continuous quality improvement in 2019 over 2018.

CHA did not plan appropriately for the 2019 measurement year. In 2018, CHA led the providers through a discussion on each measure, its specifications, and strategies for meeting the measure at both the provider and plan level. This in-depth measure analysis did not occur in 2019. One large clinic noted that the OHA metrics do not align well with other metrics to which they are held accountable. For this particular clinic, they are tracking four separate measure sets. Given the large number of OHA metrics (17 in 2019), they focused their efforts on those measures which crossed over and aligned with other measure sets.

Finally, providers noted that CHA was noticeably distracted and busy focusing on contract procurement during 2019, and this may have led to a lack of attention to the issues noted above as contributing factors to CHA's underperformance. Providers also stated they too were focused on their own internal projects or issues that were more emergent in the moment, and that this diverted their attention from metrics performance at times, especially toward the end of the year.

Not only did an increase in targets pose a challenge, so did having to see more members overall during a year hampered by provider turnover leaving some clinics extremely understaffed. Two large clinics identified provider shortages and turnover as significant barriers to better performance in 2019. This is reflected in the decline in CHA's performance on the CAHPS Access to Care measure leading to the conclusion that provider shortages contributed to a perceived lack of timely access to needed services.

Despite the many challenges encountered in 2019, providers noted an increase in collaborative efforts between all provider types, and improvement in relationships, and thanked CHA for facilitating these opportunities. Providers also noted that despite the overall under performance, in many instances, providers performed better in 2019 over 2018 on particular measures and did so with increases in their assigned member population.

External Improvement Recommendations:

1. Collaborative Strategic Planning
2. Concurrent and continuous data analysis
3. Help clinics/providers to build systems to reliably deliver high quality

Summary:

CHA's under performance on the 2019 Incentive Metrics highlighted extreme stressors during the measurement year both internally (contract procurement) and externally (provider turnover and understaffing), as well as insufficient collaborative planning. However, the single most significant finding was the lack of infrastructure within CHA itself to support a robust metrics program. Key processes were either not defined or documented, reliant on one person/position, or heavily reliant on an outside source. This deficit spilled over to the provider community and contributed to CHA's inability to support the provider community during times of extreme organizational stress. To realize success in the future, CHA must build this infrastructure, and then demonstrate continuous and sustainable use of the systems it builds. This infrastructure will then be able to support the provider community in development and execution of improvement opportunities going forward.

Data Management

In Q4 2019, data reporting and visualization transitioned from Quality Management to Business Intelligence. While this was a planned activity prior to 2019's final metrics being known and the subsequent root cause analysis, both of those events highlighted the manual and labor-intensive process used by Quality Management to report metrics performance. As noted in the above root cause analysis summary, one of the root causes of CHA's under performance was misleading data. Manual processes and relying on 3rd party vendors to produce final outputs increased the opportunity and margin for error. Additionally, many reports were published at the last minute which did not allow for thorough review and validation of the data being presented.

Business Intelligence is responsible for running the reports built internally and visualizing the data in a dashboard published through [redacted]. Dashboards are produced for both the Primary Care and Primary Dental Providers with metrics specific to each provider type. Primary Care performance is reviewed during monthly metrics meetings. Primary Dental performance is reviewed with each oral health provider on an individual basis by Provider Network.

Business Intelligence also provides customized reports based on a Report Request submission. This allows the Quality Management Department to spend less time gathering data, and more time analyzing results and strategizing improvement opportunities.

Quality Management and Case Management utilize Collective Medical (previously Pre-Manage) to identify and personalize improvement interventions for Emergency Department "super utilizers" and identify members needing additional services or supports post-hospitalization, respectively.

Reliance eHealth has been an instrumental platform during the chart scrub and validation process for the incentive metrics. Looking into 2020, Quality Management intends to better utilize both Reliance eHealth and [redacted] to identify cohorts for targeted improvement projects.

Appeals and Grievances

Cascade Health Alliance (CHA) strives to provide our members with the best health care possible. The complaint and grievance processes are an avenue by which CHA gauges member satisfaction with the providers and care received. CHA's policy is that no member, provider, or their representative will be discouraged from using any aspect of the grievance process or be encouraged to withdraw a grievance request. A grievance is defined as a member's expression of dissatisfaction with CHA or a participating provider about any matter other than an appeal or contested case hearing. It can be expressed as a concern, problem, dissatisfaction with quality of care provided, issue of interpersonal relationship (i.e. provider or employee rudeness), or a failure to respect a member's rights. Grievances can be filed by the member, their representative, or a provider.

Grievances may also be referenced as complaints and can be made to CHA in person, by phone, or in writing. All member complaints are acknowledged in writing within five (5) days of receipt. Additionally, if more time is needed to resolve the complaint, that information will be referenced in the acknowledgement of grievance letter. Resolution to all grievances must be completed with resolution sent to the member in writing within 30 days of member's complaint. per OHA guidelines, with preference for closure within five days. CHA's resolution rate is 98% within five days or less. Grievances that take longer to resolve (closer to 30 days) are those that require significant investigation. When relevant, a member's respective provider(s) are notified of the resolution. All appeal and grievance activities are documented in our Case Management software event notes, as well as on a separate log to validate and ensure the timeliness of our actions.

Members may appeal denials (Notices of Adverse Benefit Denial - NOABD), within 60 days from the date of the NOABD. Appeal decisions (Notice of Action Resolution - NOAR), are made within 16 days and are sent in writing to both the member and his or her provider. In the event the denial is "upheld" upon appeal, the member has the right to submit a request for a contested case hearing. The hearing request must be made within 120 days of the date on the NOAR.

CHA collects and monitors all appeals, grievances, and hearings data. This information is compiled and categorized on a quarterly basis based on "type" and is presented to the Quality Management Committee, Provider Network Committee, Member Experience Committee, and CHA Senior Management for review and analysis.

During 2019, CHA averaged a 1.07% complaint ratio, of which 97.7% of all grievances were resolved within five business days and none were resolved exceeding established timelines. In 2019, there were 132 appeals filed, of which 113 were related to physical health and 19 were related to oral health. There were no mental health related appeals filed. There were seven contested case hearings for 2019, of which five physical health appeals were upheld at hearing, and two appeals were overturned prior to hearing. The hearing requests that had denials that were overturned prior to hearing were: one for oral health and one physical health.

Of the 790 grievances filed in 2019, Access to Care was responsible for 49% of complaints (388) and Interaction with Provider/Plan received 45% of complaints (359). There were 3% of complaints (25) regarding Consumer Rights, Quality of Care received 2% of complaints (25), and Quality of Service and Client Billing each received two complaints, placing each of them at .02%. The highest number of grievances were regarding dental care. Of the 790 grievances filed, 541 or 68%, were regarding dental.

All complaints were investigated by CHA's Appeals and Grievances Specialist/Analyst and are referred as necessary. All NEMT complaints were forwarded to CHA's transportation vendor via Sky Lakes Outpatient Care Management and resolutions are coordinated jointly with the member. All complaints related to Consumer Rights (CR) were resolved without escalation to CHA's Compliance Officer.

CHA's 2020 strategy will continue to focus on the continual compilation and refinement of data to allow for a more comprehensive analysis to include complaints by providers and recurring complaints from individual members. Identification of trends will serve as drivers for improvement through either the Transformation and Quality Strategy (TQS), formal Performance Improvement Projects (PIPs), or CHA's internal Quality Strategy and Communication Plan, with an emphasis on both provider and member education. Additional data analysis will also allow CHA's Appeals and Grievances Specialist/Analyst to track appeals and grievances more efficiently for more accurate, timely and satisfactory resolution.

Care Coordination: Members with Special Healthcare Needs

CHA's Case Management Department coordinates the care of members with Special Healthcare Needs.

In 2019, CHA leveraged technical assistance from the Oregon Pediatric Improvement Partnership (OPIP) to take a deeper dive into its pediatric member population with high health complexity, determined by an algorithm of combined medical and social complexity. With assistance from OPIP, CHA plans to begin work on a dedicated performance improvement project in early 2020 to include improvements in both social service provision and health outcomes. CHA is also planning to hire a Pediatric Nurse Case Manager in 2020 whose work will be an integral of the planned project.

Cascades East Family Practice (an Oregon Health Sciences University residency program) continues to lead a focused multidisciplinary team, which meets weekly to review cases of the highest risk utilizers of their patient population. This includes not only high utilizers of services, i.e. Emergency Department (ED), but also includes patients who may be "falling through the cracks," or experiencing complex or complicating factors. The team is composed of triage nurses, care managers from Outpatient Care Management, an RN Case Manager from CHA, as well as the CHA Behavioral Health Case Manager. Also, in regular attendance are representatives from other providers as needed, as well as the Community Mental Health Provider (KBBH) to help address Behavioral Health and Substance Use Disorder (SUDS) needs. To this end, in 2019, the group expanded focus to regularly discuss members receiving Medication Assisted Treatment (MAT) services. Although the team's original purpose was to review members' most recent use of the ED, it has expanded to address a myriad of other barriers facing members, including Social Determinants of Health (SODH). CHA continues to support the efforts of other local clinics in convening similar groups to address the same issues among their respective patient populations, and there have been attempts at growing other such groups.

The quality and appropriateness of care provided to members is also assessed during Utilization Review Committee meetings. The URC is responsible for monitoring over/under utilization of clinical services, including hospital readmissions. Committee members lend their expertise regarding second opinions, reconsiderations, appeals, and clinical guidelines. Concerns raised during the utilization review process and review of complaints and grievances, are all considered when reviewing the quality and appropriateness of care provided to our members. Concerns are addressed either by the Chief Operations Officer and Provider Network Manager during one-on-one meetings with individual providers, or in some instances, by more intensive oversight by the Quality Management Committee during the credentialing process.

The Director of Case Management left the agency in late November 2019. The position's job description was updated to reflect the need for focused attention on Behavioral Health integration. CHA looks forward to hiring a Director of Behavioral Health and Case Management in early 2020.

Quality and Appropriateness of Care

The quality and appropriateness of care provided to members is assessed by several CHA departments and Board commissioned committees which provides a well-rounded and comprehensive review of CHA's provider network.

The Utilization Review Committee (URC) monitors service utilization against the practice guidelines and treatment protocols approved by the Quality Management Committee (QMC). The QMC establishes expectations for providers to follow the guidelines established by the United States Preventive Services Task Force (USPSTF) and Bright Futures (Guidelines for Health Supervision of Infants, Children, and Adolescents) in the *Health Promotion and Prevention Policy and Procedure, PP09006*.

The Utilization Review Committee is responsible for monitoring over/under utilization of clinical services, including hospital readmissions. Committee members lend their clinical expertise regarding second opinions, reconsiderations, appeals, best practices, and clinical guidelines. Concerns raised during the utilization review process and review of complaints and grievances, are all considered when reviewing the quality and appropriateness of care provided to our members. Concerns are addressed either by the Chief Operations Officer and Provider Network Manager during one-on-one meetings with individual providers, or in some instances, by more intensive oversight by the Quality Management Committee during the credentialing process.

Business Intelligence is responsible for aggregating and distributing data to assess member access to care based on the number of services provided to members, number of assigned members seen, and members assigned against the providers capacity to accept new members. This information is used by Provider Network to determine the need to expand the network or identify a provider performance concern which needs to be addressed. Through analysis of the DSN (Delivery Service Network) report, CHA determines how many out of network providers are being utilized to meet the needs of members. This is another tool CHA uses to assess its network adequacy and capacity.

Timely access to services is key to providing high quality care and improving health outcomes. Complaints, grievances, and requests by members for provider reassignment are several ways in which CHA is made aware of concerns regarding timely access. The Chief Operations Officer and Provider Network Manager work directly with providers to remediate any significant concerns regarding access.

Member Services continued its initiative to reach new members within 30 days of assignment to Cascade Health Alliance. Member Services contacts each new member to ensure they have received their member ID card and new member packet. They are assigned a Primary Care Provider as well as a Primary Dental Provider. Member Services reviews their provider assignments, benefits, and inquires as to cultural or language barriers that may hinder their access to care. Members with identified needs are referred to CHA's Case Management Department for further assessment and follow-up. CHA provides immediate access to translation services for both member and provider use when needed.

The Compliance Department audits provider charts on a regular rotating schedule. Audit reports are sent to providers with the requirement of corrective action plans when indicated.

The Quality Management Department meets with primary care providers monthly to review CHA and individual clinic performance on the OHA Incentive Metrics. Care gap lists are sent to providers upon request for establishment of appointments for necessary annual visits and/or screenings. Care gap lists are also sent to participating oral health providers by Provider Network for the same purpose.

Health Equity

As part of the development of CHA's Health Equity Plan, CHA conducted a community-wide Health Equity Assessment summer and early fall 2019. Several focus groups were held consisting of network providers, CHA staff, members (through both the Community Advisory Council and a survey administered through Klamath Health Partnership), and various community partners (i.e. Blue Zones, Healthy Klamath, Klamath County Public Health). Based on feedback from all the participating groups, Social and Community Health emerged as a top priority for initial stages of execution of CHA's Health Equity Plan. CHA's Transformation and Quality Strategy reflects this direction with projects focusing on activities to better facilitate CHA's understanding of underlying social issues within our community through data collection and reporting, the need to be more culturally responsive to members and their cultural needs, and be more responsive to members with special health care needs, mental illness, and multiple chronic conditions. CHA's performance improvement projects both support and supplement the work outlined in this document.

Oregon Health Authority Quality Health Outcomes Committee

Three members of the Quality Management team were active participants in the OHA's Quality Health Outcomes Committee (QHOC) in 2019: Medical Director, Director of Quality Management, and a Quality Management Analyst. Meetings are held in Salem on the second Monday of every month. Each session is followed by a Quality Improvement Learning Collaborative whose topics range from discussion or technical assistance on specific incentive metrics, performance improvement projects, External Quality Review, TQS expectations, etc. CHA representatives attend via phone or in person (weather permitting).

The Quality Management team is also an active participant in the OHA's Technical Advisory Group (meets every other month), and an active listener at the Metrics and Scoring Committee's monthly meeting.

Quality Management Goals - 2020

Quality Management has identified the following Operational Excellence goals for 2020:

1. Develop knowledge base and skill set of the QM team in Quality tools to promote effective utilization, analysis, and execution of improvement projects. This goal will be accomplished through the following strategic tactics:
    - Implement targeted staff training
    - Encourage and promote a learning culture
    - Add training to QM team meetings

2. Identify and implement process improvement to increase task and reporting efficiency. This goal will be accomplished through the following strategic tactics:
    - Data analysis and implementation of strategies for achievement to occur earlier in the measurement year
    - Clearly define staff and provider roles and responsibilities for accountability
    - Improve application of data analysis capabilities
    - Broaden repertoire of data analysis and visualization tools

3. Improve internal interdepartmental partnership and teamwork. This goal will be accomplished through the following strategic tactics:
    - Increase visibility at department team meetings to bring focus to metrics and performance
    - Promote open and transparent communication
    - Shift Q-Tip focus to specific actionable items for staff execution to improve metric performance

By achieving these Operational Excellence goals, the Quality Management department will be able to successfully achieve the following department level goals:

1. Achieve 100% of the OHA Incentive Pool allocation (10 of 13 measures)
2. Create and execute venue and instrument for involvement and integration of oral health providers in performance and service delivery discussions to encourage provider collaboration and improved coordination of care for members
3. Execution of performance improvement projects that demonstrate true improvement through documented achievement of identified outcomes measures
4. Demonstrate a 4 Star trend for Medicare Advantage products (both PPO and SNP)

The department firmly believes that “Quality is Everybody’s Business” necessitating the involvement and collaboration of all departments to bring about transformation and

improvement in the health outcomes of our members. This view lays the foundation for the work going forward in 2020.

Compliance Committee Charter

I. CHARTER STATEMENT

The Compliance Committee is created and charged by the Cascade Comprehensive Care (CCC)/Cascade Health Alliance (CHA) Boards to perform risk framing/assessment activities and make recommendations to the CCC/CHA Boards for action and response to reduce regulatory, privacy and compliance risks facing the organization.

II. PURPOSE:

The purpose of the Compliance Committee is to:

1. Develop strategies and tactics to receive, assess and analyze information from varying sources to identify regulatory and compliance risks facing the organization given its operations, information technology, privacy and business plans.
2. To make recommendations to the CCC/CHA Boards on the importance, severity and priority of exposure areas facing the organization. In addition, to recommend possible actions to further determine the extent of possible exposure and/or to remedy and lessen present or anticipated risks.
3. Support the establishment of procedures to assist the CHA Compliance and Privacy Officer in executing and implementing the CHA Compliance Program.
4. Create a forum for Compliance Committee which is comprised of CHA Board members to provide input and direction to the CHA Compliance Officer and obtain key information about identified risks facing the organization and risk mitigation plans.
5. Oversee the implementation and progress of action and monitoring plans designed to reduce risk and support compliance with applicable laws, regulation and company policies.

III. SCOPE:

The Compliance Committee activities include those delegated to it by the CCC/CHA Boards in support of the Compliance Program for organization. In so doing, the Compliance Committee shall ascertain the acceptability of proposed activities when weighed against organizational commitments, goals, regulations, applicable law, and standards of professional conduct and practice.

IV. RESPONSIBILITIES

Responsibilities of Compliance Committee include, but are not limited, to the following:

- Help ensure compliance objectives are being adequately addressed and high impact compliance risks are identified, assessed and reported to the CCC/CHA Boards.

- Identify, review and assess compliance/risk issues brought forward by CHA Senior Leadership, employees, external stakeholder and plan members and other risk framing information sources.
- Create a compliance risk response plan that includes prioritizing high-risk areas and making recommendations for addressing risk areas.
- On-going assessment of progress with compliance work plans
- Present Annual Report of activities to CCC/CHA Boards.

V. MEETINGS

The Compliance Committee meets no less than quarterly per year. Additional meetings may be called by the Compliance Committee Chairperson to establish greater meeting frequency necessary to conduct the business of the committee and to address critical issues in a timely manner.

The Compliance Committee Chairperson and the Compliance and Privacy Officer or designee will set meeting dates, times, locations and agendas.

VI. MEMBERSHIP

The membership of the committee shall be comprised of

- 3 members of the CHA Board
- CHA CEO
- CHA COO, Compliance and Privacy Officer

Role of a Compliance Committee Member

It is intended that the Compliance Committee leverage the experiences, expertise, and insight of key individuals across a wide spectrum of functions within the organization. Individually committee members should:

- Appreciate the expression and constructive discussion of diverse viewpoints. Understand that each committee member has an equal and full opportunity to express opinions and otherwise contribute to the process.
- Submit risk issues or topics for discussion prior to any meeting for inclusion on the meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend Compliance Committee meetings consistently or assign a Chairperson approved delegate (if needed).
- Participate in risk framing exercises and be familiar with how the activities of the committee are relevant to the CHA Compliance and Privacy Programs.

VII. MEETING STANDARDS

1. QUORUM - a quorum shall exist with at least 50% of the membership in attendance.
2. GUESTS - the Chairperson of the CHA Compliance Committee and the Chief Operations Officer and Compliance and Privacy Officer is permitted to invite as a guest of the committee persons knowledgeable on subjects and issues before the committee, to support educational aspects and provide expertise to the committee when necessary.

3. MINUTES - meeting minutes shall be developed by the Compliance Committee "Recorder" to reflect the actions of the committee. Draft minutes of each meeting shall be submitted to the members of the committee for review and approval prior to the subsequent meeting. The final/approved meeting minutes shall be provided at the next regularly scheduled meeting of the committee.

VIII. SUB COMMITTEES / WORK GROUPS

The Compliance Committee shall in its discretion create and charter formal sub-committees, informal work groups, and engage external consultants and other resources deemed necessary to carry out the activities of the committee. The Compliance Committee shall receive updates from and shall oversee subcommittees and work groups that are created and delegated Compliance Program activities. The Compliance Committee retains its responsibility as delegated to it by the CCC/ CHA Boards. The CCC/CHA Boards remains responsible for the overall activities of the Compliance Program, regardless of the use of subcommittees and work groups.

IX. CHARTER REVIEW

This Compliance Committee charter shall be reviewed annually. Material revisions to the Charter shall be approved by the CHA Board.

X. CHARTER APPROVED

Date Chartered: April 10, 2018

Chairperson

Chief Operations Officer

Provider Network Management Committee Charter

I. CHARTER STATEMENT

The Provider Network Management (PMN) committee is created and charged by the Chief Executive Officer (CEO) to perform analysis, assessment, identify areas of opportunity for provider network adequacy, capacity and performance to serve the Cascade Health Alliance (CHA) membership.

II. PURPOSE:

The purpose of the Committee is to:

1. Utilize policies, guidelines and ratios to assess Provider Network adequacy and capacity for CHA provider network. This will include physical, behavioral and dental practitioners.
2. Develop and monitoring key performance indicators and established goals/thresholds through and reporting and dashboards. Identify areas requiring action plans to address adequacy and capacity concerns.
3. Make recommendations and actions to the COO on the importance and priority of addressing provider network adequacy and capacity concerns.
4. Develop and support the establishment of procedures to assist CHA and CCC in executing and implementing provider network strategies.

III. SCOPE:

- The PNM will focus on Support development of regional PNM monitoring tools to support compliance with rules, laws, and the Oregon Health Authority contract.
- Provide requested information and support development of periodic Network Capacity and adequacy assessment.
- Monitor results of provider panel to identify potential network adequacy and capacity needs.
- Support development and implementation of a Provider Network Strategic Plan.
- Look for opportunities and recommend strategies to establish uniformity in contract language.
- Provider clinic education, training and material.
- Monitoring of provider key performance indicators.

IV. RESPONSIBILITIES

Responsibilities of PNM include, but are not limited, to the following:

- Monitoring and reporting provider network adequacy and capacity.
- Recommendations and development for strategies and action plans to ensure appropriate access of providers and dentist is maintained for the membership.
- Development of reports to monitor progress and impacts of changes in network.
- Identify and review provider panel issues brought forward by members, stakeholders, CCC employees or providers.
- Develop and monitor corrective action plans.
- Monitoring of appeals and grievances.
- Key metric performance indicators.

V. MEETINGS

The PNM will meet at least quarterly. Additional meetings may be called by the COO/Chairperson to establish greater meeting frequency necessary to conduct the business of the Committee and to address critical issues in a timely manner.

The PNM Chairperson or designee will set meeting dates, times, locations and agendas.

VI. MEMBERSHIP

The membership of the Council shall be comprised of (but not limited to):

- Chief Operations Officer
- Chief Medical Officer
- Manager of Provider Network
- Director of Member Experience
- Director of Decision Support and Business Intelligence, or delegate
- Director of Quality, or delegate

Composition shall be reviewed from time to time, as necessary to reflect CHA's and CCC's evolving organizational structure and the oversight needs of our business. The Chief Operations Officer or their designee (if needed) shall serve as the Council chairperson.

Role of a PNM Member

It is intended that the PNM leverage the experiences, expertise, and insight of key individuals across a wide spectrum of functions within the organization. Individual Council members should:

- Appreciate the expression and constructive discussion of diverse viewpoints. Understand that each Council member has an equal and full opportunity to express opinions and otherwise contribute to the process.
- Submit issues or topics for discussion prior to any meeting for inclusion on the meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend OC meetings consistently or assign a Chairperson approved delegate (if needed).
- Participate in framing exercises and be familiar with how the activities of the Council are relevant to all lines of business.

VII. MEETING STANDARDS

1. Guests - the Chairperson of the PNM is permitted to invite as a guest of the Committee persons knowledgeable on subjects and issues before the Committee, to support educational aspects and provide expertise to the Committee when necessary.

2. Agenda and Minutes - meeting agenda and minutes shall be developed by a designee of the Chairperson and be identified as the meeting "Recorder" to reflect the actions of the Committee. Agenda and draft minutes of each meeting shall be submitted to the members of the Committee for review at least two business days to the subsequent meeting. The final/approved meeting minutes shall be provided at the next regularly scheduled meeting of the Committee.

VIII. SUB COUNCILS / WORK GROUPS

The PNM shall in its discretion create and charter formal sub-Councils, informal work groups, and engage external consultants and other resources deemed necessary to carry out the activities of the Council. The PNM shall receive updates from and shall oversee sub councils and work groups that are created and delegated PNM activities. The PNM retains its responsibility as delegated to it by the COO.

IX. CHARTER REVIEW

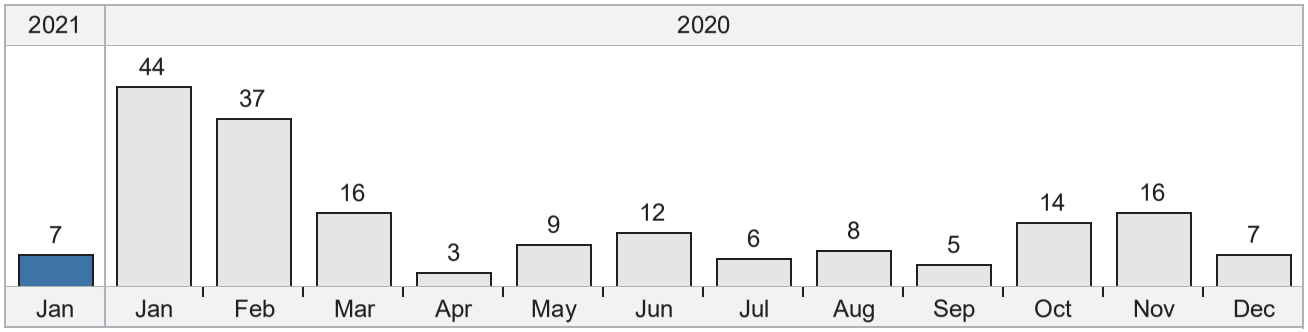
This PNM charter shall be reviewed annually at a minimum. Material revisions to the Charter shall be approved by the COO.

Approval and Review	**Date(s)**
Revision Date	06/20/2018, 10/04/2019
Committee Approval	06/20/2018, 10/09/2019
Chief Operating Office Approval	06/20/2018, 10/09/2019
Next Review Date	06/20/2019, 10/2020

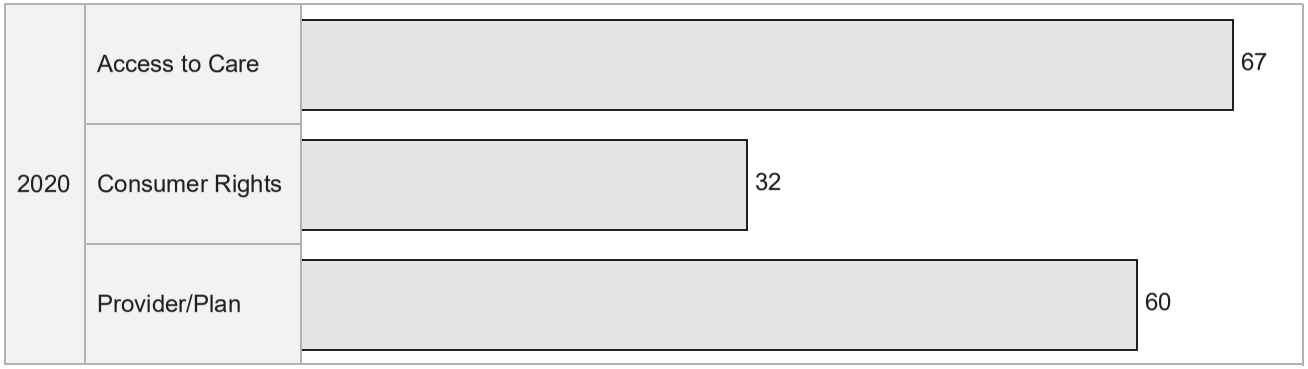
2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance

Grievances by Quarter



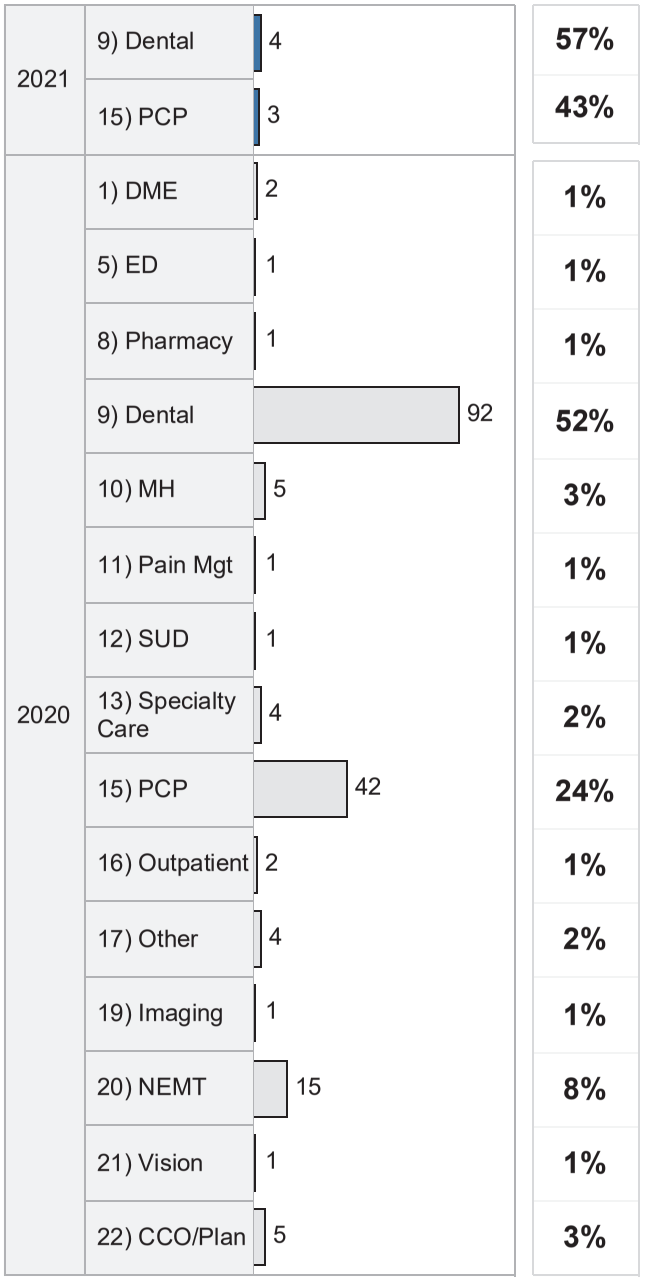
Top 3 Grievance Categories by Year



Average Resolution (Days)

2021	2020			
Q1	Q1	Q2	Q3	Q4
0.00	**1.41**	**0.33**	**7.11**	**2.16**

Grievances by Service Type



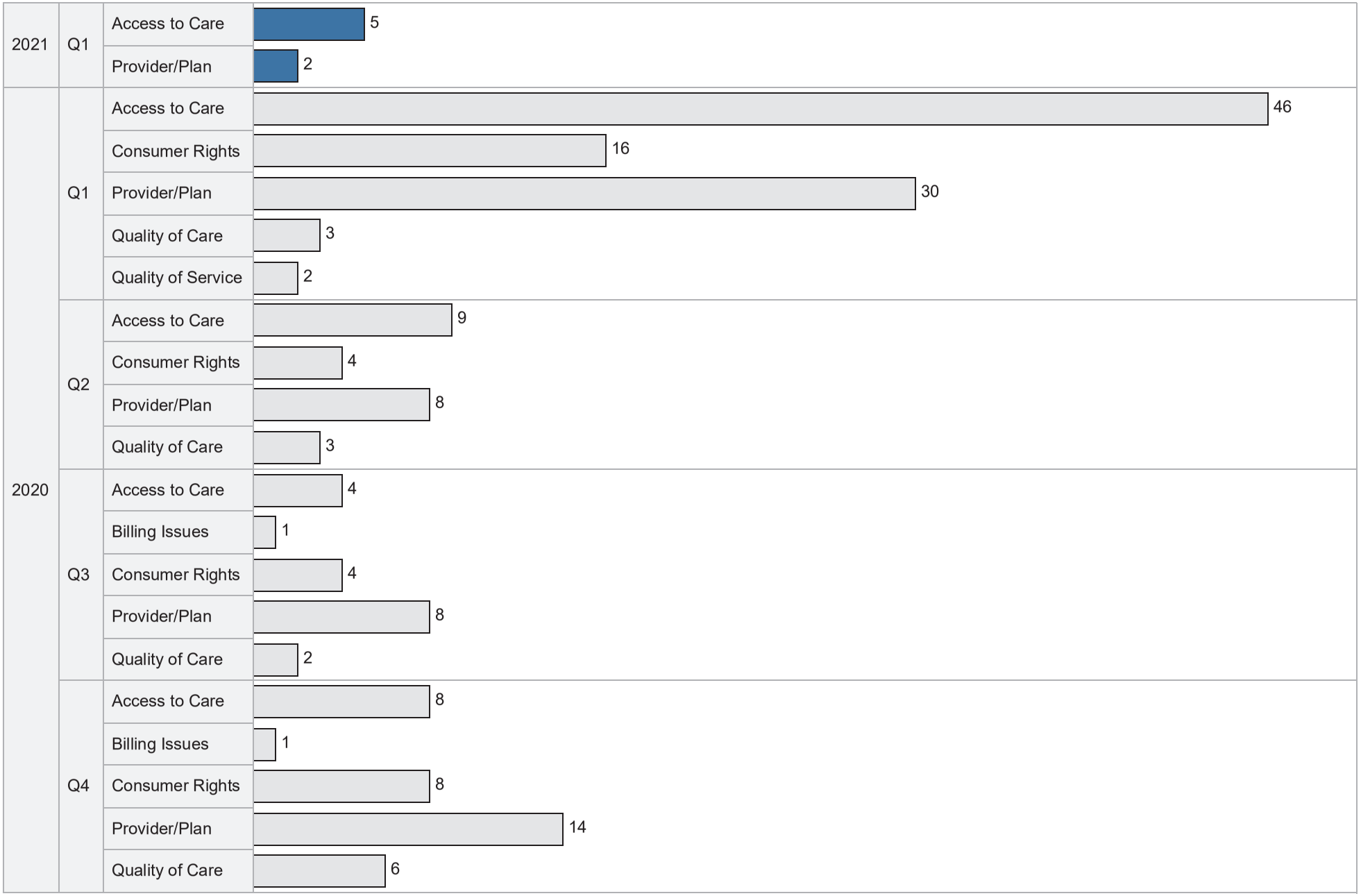
Grievance Activity: 01/01/2020 - 01/31/2021 **Updated:** 02/16/2021 **Source:** [redacted] and Compliance

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance, LLC

Grievances by Category



Grievance Activity: 01/01/2020 - 01/31/2021 **Updated:** 02/16/2021 **Source:** [redacted] and Compliance

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance, LLC

Count of Grievances - Service Type 9 (Oral Health)

	CHASE FAMILY DENTISTRY	GENERAL DENTISTRY	KLAMATH DENTAL CENTER	KLAMATH HEALTH PARTNERSHIP PCD	KLAMATH SMILES	MORTENSON FAMILY DENTISTRY	OREGON INSTITUTE OF TECHNOLOGY	SHASTA FAMILY DENTAL	TIMBER KIDS DENTISTRY	TUCKER & GAILIS DENTAL	WASHBURN SMILES	WESTERN DENTURE	**Total**
A.a) Provider's office unresponsive, not available, difficult to contact for appt or info			1	2			2		10		5		**20**
A.c) Provider's office too far away, not convenient											2		**2**
A.d) Unable to schedule appointment in a timely manner				5				4	1		4		**14**
A.e) Unable to be seen in a timely manner for urgent/emergent care				1				1			2		**4**
A.i) Provider not available to give necessary care								1			7		**8**
CR.c) Member dissatisfaction with treatment plan (not involved)	1			4				1	2		6		**14**
IP.a) Wants to change providers; provider not a good fit				1				2			6		**9**
IP.b) Provider rude or inappropriate comments or behavior	1		2								4	1	**8**
IP.d) Provider explanation/instruction inadequate/incomplete											1		**1**
IP.e) Plan explanation/instruction inadequate/incomplete											1		**1**
IP.f) Wait too long in office before receiving care											6		**6**
IP.g) Member not treated with respect and due consideration for dignity and privacy									1		1		**2**
IP.m) Dismissed by clinic (member misbehavior, miss appts, etc.)	1												**1**
QC.a) Received appropriate care, but experienced an adverse outcome			1	3							2		**6**
Total	**3**	**0**	**4**	**16**	**0**	**0**	**2**	**9**	**14**	**0**	**47**	**1**	**96**

1 — 10

Grievance Activity: 01/01/2020 - 01/31/2021 **Updated:** 02/16/2021 **Source:** [redacted] and Compliance

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance, LLC

Count of Grievances - Service Type 15 (PCP)

	CASCADES EAST FAMILY PRACTICE	KLAMATH HEALTH PARTNERSHIP PCP	SANFORD CHILDRENS CLINIC	SKY LAKES PRIMARY CARE	THE CHILDRENS CLINIC	THE MERRILL CLINIC	**Total**
A.a) Provider's office unresponsive, not available, difficult to contact for appt or info			1				**1**
A.d) Unable to schedule appointment in a timely manner		4	3				**7**
A.e) Unable to be seen in a timely manner for urgent/emergent care		3					**3**
A.i) Provider not available to give necessary care		1	2				**3**
CR.c) Member dissatisfaction with treatment plan (not involved)	4			2		1	**7**
CR.d) No choice of clinical or clinician choice not available	1						**1**
IP.a) Wants to change providers; provider not a good fit		2	2	2	2		**8**
IP.b) Provider rude or inappropriate comments or behavior	2	5	1	1			**9**
IP.d) Provider explanation/instruction inadequate/incomplete			2	1	1		**4**
QC.a) Received appropriate care, but experienced an adverse outcome				1			**1**
QC.c) Concern about prescriber or medication or medication management issues	1						**1**
Total	**8**	**15**	**11**	**7**	**3**	**1**	**45**

Grievance Activity: 01/01/2020 - 01/31/2021 **Updated:** 02/16/2021 **Source:** [redacted] and Compliance

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance, LLC

Count of Grievances - Excluding Service Type 9 (Oral Health) and 15 (PCP)

	CHA PHARMACY	DURABLE MEDICAL EQUIPMENT	GENETIC TESTING	INDIVIDUAL & FAMILY GROWTH CENTER	KLAMATH BASIN BEHAVIORAL HEALTH	KLAMATH EYE CENTER	KLAMATH ORTHOPEDIC	NEMT	OHP	PLAN/PROGRAM	SKY LAKES DERMATOLOGY	SKY LAKES EMERGENCY DEPT	SKY LAKES OUTPATIENT IMAGING	SKY LAKES PRIMARY CARE	SKY LAKES RHEUMATOLOGY	VERACYTE	**Total**
A.d) Unable to schedule appointment in a timely manner							1										**1**
A.l) NEMT not provided, late pick up with missed appointment, no coordination of services								9									**9**
CB.c) Billing OHP clients without a waiver			1													1	**2**
CR.b) Concern over confidentiality					1												**1**
CR.c) Member dissatisfaction with treatment plan (not involved)					2				1	3		1		1			**8**
CR.d) No choice of clinical or clinician choice not available															1		**1**
IP.a) Wants to change providers; provider not a good fit					1			1									**2**
IP.b) Provider rude or inappropriate comments or behavior				1	3						1						**5**
IP.e) Plan explanation/instruction inadequate/incomplete								2		2							**4**
IP.k) Lack of communication and coordination among providers						1		1									**2**
QC.a) Received appropriate care, but experienced an adverse outcome								1					1				**2**
QC.c) Concern about prescriber or medication or medication management issues	1				2												**3**
QC.e) Provider office unsafe/unsanitary environment or equipment								1									**1**
QS.a) Delay in receiving or concern regarding quality of materials/supplies (DME) or dental		1								1							**2**
Total	**1**	**1**	**1**	**1**	**9**	**1**	**1**	**15**	**1**	**6**	**1**	**1**	**1**	**1**	**1**	**1**	**43**

1 — 9

Grievance Activity: 01/01/2020 - 01/31/2021 **Updated:** 02/16/2021 **Source:** [redacted] and Compliance

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 GRIEVANCES Feb 2021

Cascade Health Alliance, LLC

"A" = Access to Care

A.a) Provider's office unresponsive, not available, difficult to contact for appt or info
A.b) Plan unresponsive, not available, difficult to contact for appointment or information.
A.c) Provider's office too far away, not convenient
A.d) Unable to schedule appointment in a timely manner.
A.e) Unable to be seen in a timely manner for urgent/emergent care
A.f) Provider's office closed to new patients.
A.g) Referral or 2nd opinion denied/refused by provider.
A.h) Referral or 2nd opinion denied/refused by plan.
A.i) Provider not available to give necessary care
A.j) Eligibility issues
A.k) Female or male provider preferred, but not available
A.l) NEMT not provided, late pick up w/missed appointment, no coordination of services
A.m) Dismissed by provider as a result of past due billing issues
A.n) Dismissed by clinic as a result of past due billing issues
A.o) Verbal denial of service by Provider
A.p) Verbal denial of service by Plan

"CR" = Consumer Rights

CR.a) Provider's office has a physical barrier/not ADA compliant, prevents access to office, lavatory, examination room, etc.
CR.b) Concern over confidentiality.
CR.c) Member dissatisfaction with treatment plan (not involved, didn't understand, choices not reflected, not person centered, disagrees, tooth not restorable, preference for individual settings vs. group, treatment options not discussed)
CR.d) No choice of clinical or clinician choice not available
CR.e) Fraud and financial abuse
CR.f) Provider/Plan bias barrier (age, race, religion, sexual orientation, mental/physical health, marital status, Medicare/Medicaid)
CR.g) Complaint/appeal process not explained, lack of adequate or understandable NOA
CR.h) Not informed of consumer (Member) rights
CR.i) Member denied access to medical records (other than as restricted by law)
CR.j) Did not respond to members request to amend inaccurate or incomplete information in the medical record (includes right to submit a statement of disagreement)
CR.k) Advanced or Mental Health Directive not discussed, offered or followed.
CR.l) Concern that a form of restraint or seclusion was used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. Restraint or seclusion used other than to assure members immediate safety.

"CB" = Client Billing Issues

CB.a) Co-pays
CB.c) Member complaint about OHP clients receiving a bill, without signing a waiver

"IP" = Interaction with Provider or Plan

IP.a) Wants to change providers; provider not a good fit
IP.b) Provider rude or inappropriate comments or behavior
IP.c) Plan rude or inappropriate comments or behavior
IP.d) Provider explanation/instruction inadequate/incomplete
IP.e) Plan explanation/instruction inadequate/incomplete
IP.f) Wait too long in office before receiving care
IP.g) Member not treated with respect and due consideration for his/her dignity and privacy
IP.h) Provider's office or/and provider exhibits language or cultural barriers or lack of cultural sensitivity, interpreter services not available.
IP.i) Plan's office or staff exhibits language or cultural barriers or lack of cultural sensitivity
IP.j) Member has difficulty understanding provider due to language or cultural barriers.
IP.k) Lack of communication and coordination among providers
IP.l) Dismissed by provider (member misbehavior, missed appts. etc.)
IP.m) Dismissed by clinic (member misbehavior, missed appts. Etc.)

"QC" = Quality of Care

QC.a) Received care, experienced an adverse outcome, complications, misdiagnosis or concern related to provider care.
QC.b) Testing / assessment insufficient, inadequate or omitted
QC.c) Concern about prescriber or medication or medication management issues (prescribed non-formulary medication, unable to get prescription filled or therapeutic alternative recommended by Provider or Plan)
QC.d) Member neglect or physical, mental or psychological abuse
QC.e) Provider office unsafe/unsanitary environment or equipment
QC.f) Lack of appropriate individualized setting in treatment.

"QS" = Quality of Service

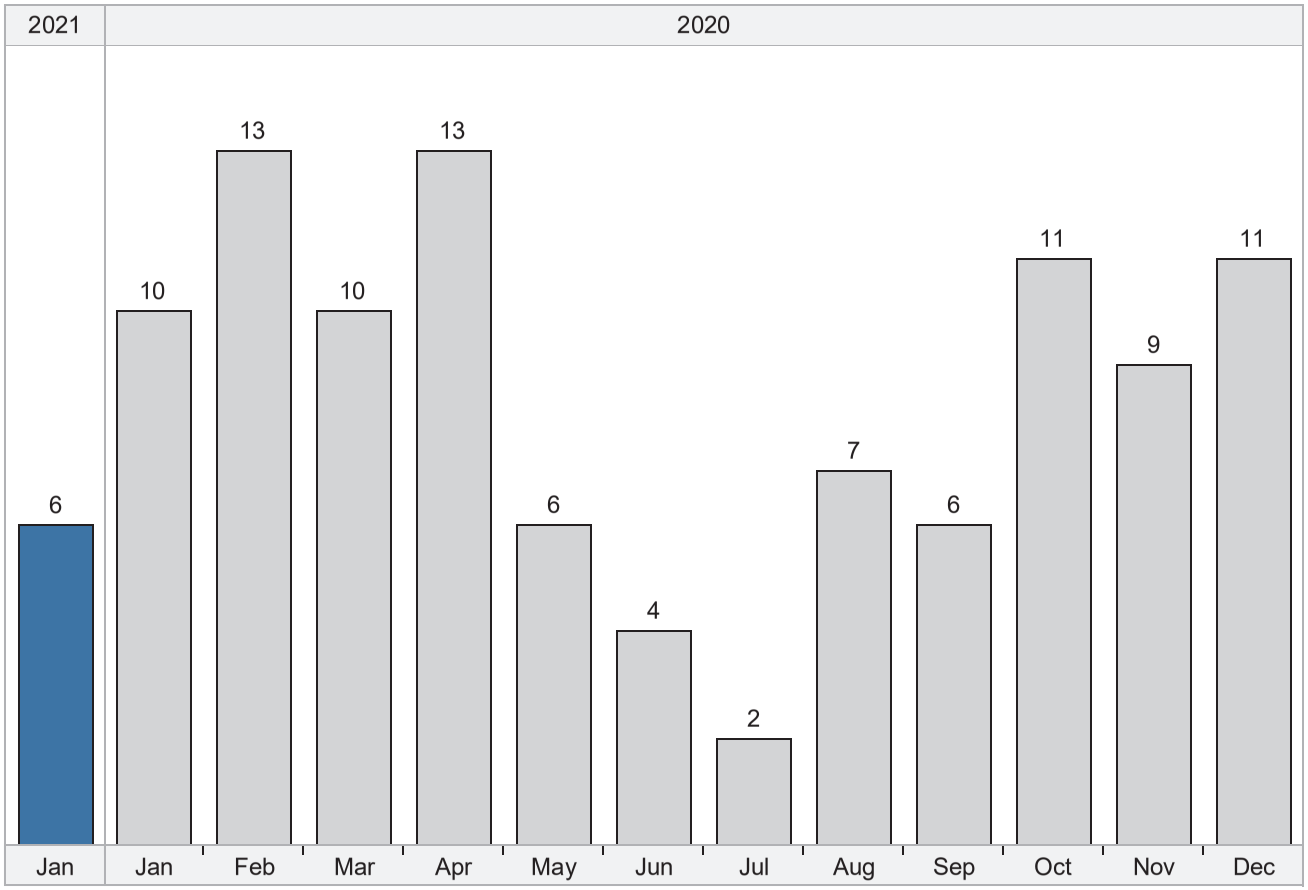
QS.a) Delay in receiving or concern regarding quality of materials and supplies (DME) or dental
QS.c) Benefits not covered

Created Date: 02/16/2021
Created By: Danielle Sherman

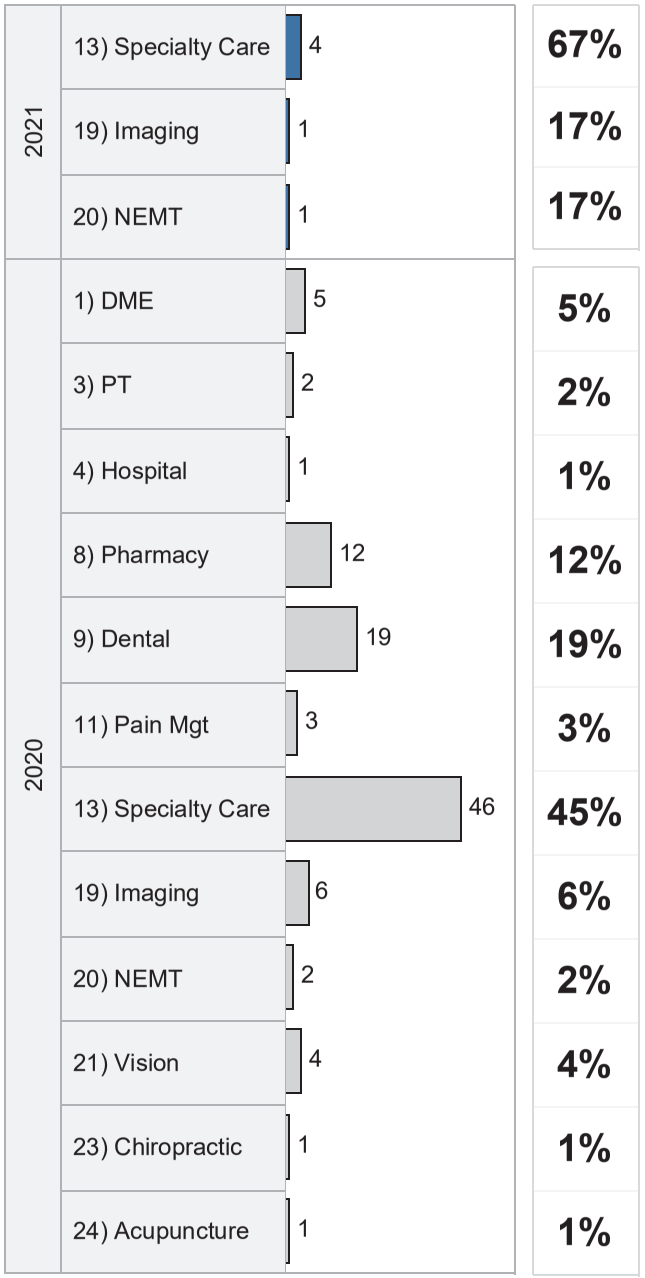
2020/2021 APPEALS (NOAR) Feb 2021

Cascade Health Alliance

Appeals by Quarter



Appeals by Service Type



Average Determination (Days)

2021	2020			
Q1	Q1	Q2	Q3	Q4
4.00	**5.76**	**4.36**	**5.67**	**3.00**

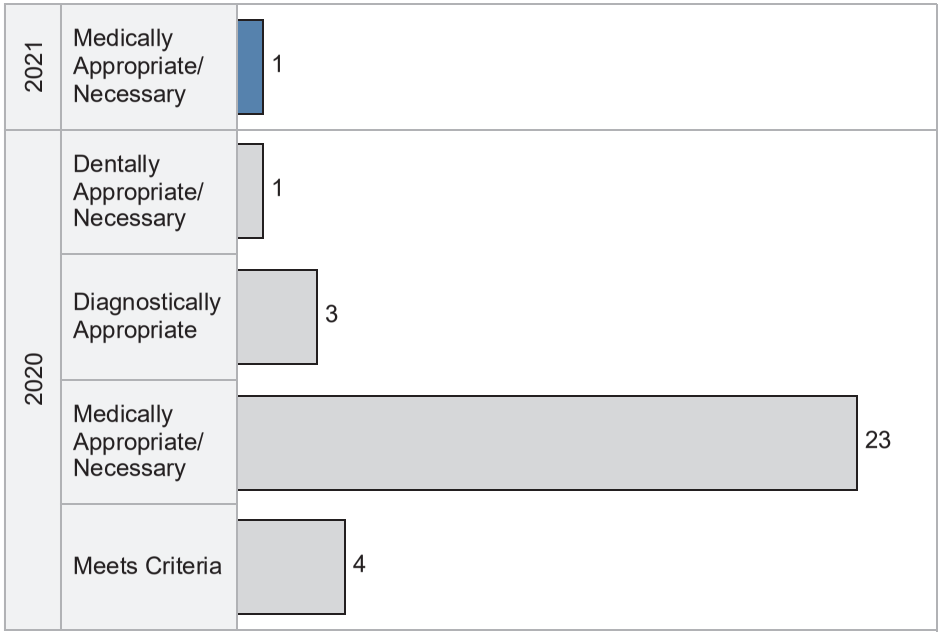
Appeal Requests: 01/01/200 - 01/31/2021 **Updated:** 02/12/2020 **Source:** [redacted] and Sky Lakes

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 APPEALS (NOAR) Feb 2021

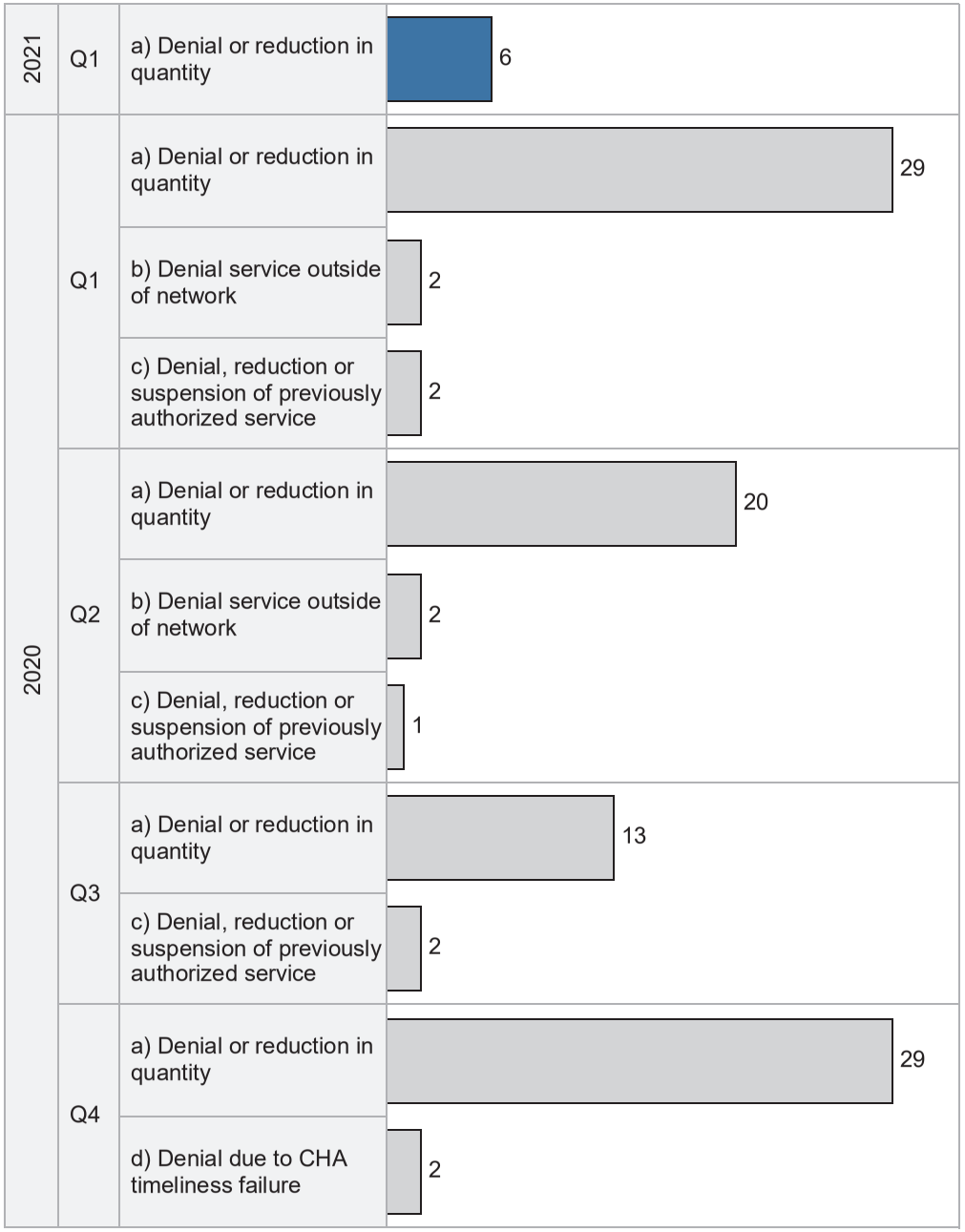
Cascade Health Alliance, LLC

Overturned Appeals



		Overturned	Total	Percent Overturned
2021	Q1	1	6	16.7%
2020	Q1	9	33	27.3%
	Q2	7	23	30.4%
	Q3	4	15	26.7%
	Q4	11	31	35.5%

Appeals by Action Category



Appeal Requests: 01/01/200 - 01/31/2021 **Updated:** 02/12/2020 **Source:** [redacted] and Sky Lakes

Created Date: 02/16/2021
Created By: Danielle Sherman

2020/2021 APPEALS (NOAR) Feb 2021

Cascade Health Alliance

Action Category

a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. 42 CFR §438.400(b)(1)
Explanation: A member or member's doctor requests a servcie and the MCE determines the member:
- Cannot have the service;
- Can have the service, but not the number or in the service requested (ex. A member requests 10 PT visits, but is only granted 5 PT visits or, a member requests 3 month supply of medication, but they are only granted 1 month supply);
- The service requested is for a setting that the MCE believes is not appropriate (ex. A member requests to have a dental procedure in a hospital, bu the MCE dcides the member does not meet MCE criteria for a hopsiatl dental procedure);
- Requested a service that is determined by the MCE to be experimental, investigative, or not medicall necessary;
- Was/is not eligiblt for OHP at the time services were/are requested;
- Requested a service that is not a covered service; or
- Record is missing information necessary for the MCE to approve the requested service.

b) Denial of a member's request to obtain services outside the managed care entity panel. Use this category when the MCE is denying a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network (42 CFR 438.400(b)(6).
Explanation: When an MCE does not agree (approve) to let a member access services outside of the MCE provider network, this is an adverse benefit determination.

c) The reduction, suspension, or termination of a previously authorized service. 42 CFR §438.400(b)(2)
Explanation: When the MCE stops or decreases a service a member is already receiving, this is an ABD.

d) The failure of an MCE to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. 42 CFR §438.400(b)(5)
Explanation: When the MCE stops or decreases a service a member is already receiving, this is an ABD.

e) The failure to provide services in a timely manner, as defined by the State. 42 CFR §438.400(b)(4)
Explanation: When a member has to wait longer than standard, urgent or emergency timeframes in the MCE Contract and OAR to get health care or receive a service, this is an ABD and the MCE must send the member an NOABD.

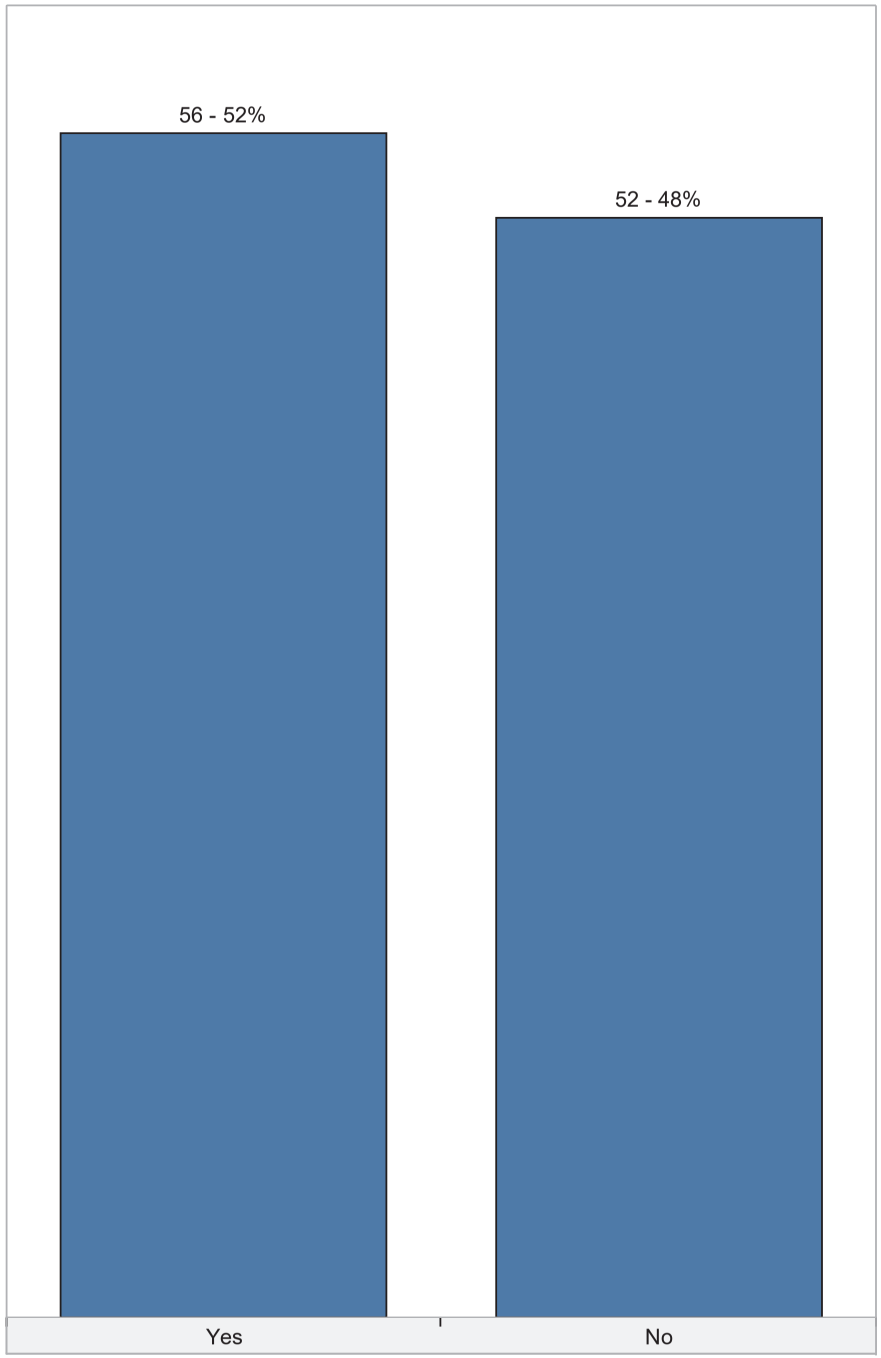
f) The denial, in whole or in part, of payment for a service. 42 CFR §438.400(b)(3)
Explanation: a member has already received a service, but the MCE determines that it cannot pay for the service; this is an adverse benefit determination.

g) Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. Use this category for ABD issued by the MCE to deny a member's request to dispute a financial liability (42 CFR 438.400(b)(7).
Explanation: A member received a bill for services that they believe the MCE should have paid for, but didn't. If the MCE investigates and determines that the member signed an 'agreement to pay form' and the member is required to pay, the MCE must send the member a NOABD.

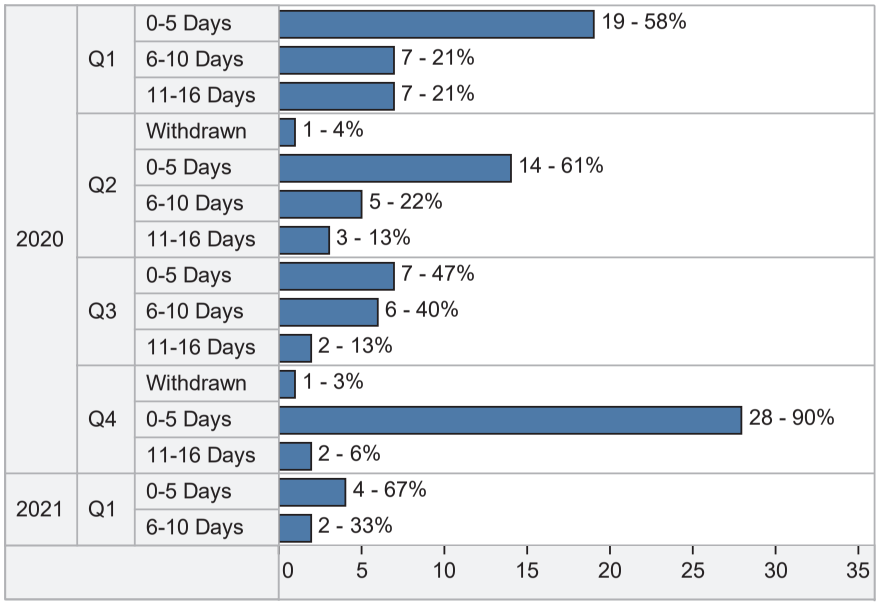
Sub Category Catories a, c, and f must have a sub category

1) Treatment is not a covered service
2) Requires PA and was not preauthorized (includes non-panel provider requirement for PA)
3) The service is not medically appropriate
4) The service or item was received in an emergency care setting and does not qualify as an emergency service.
5) The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior authorization would be required under OHP rules)

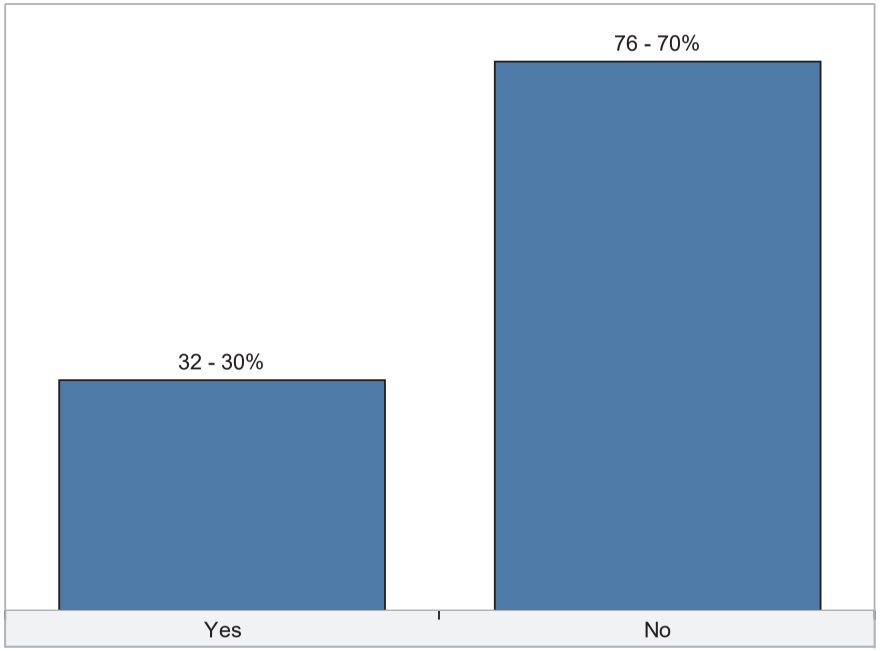
Expedited Requested?



Appeals by Determination Time and Quarter (2)



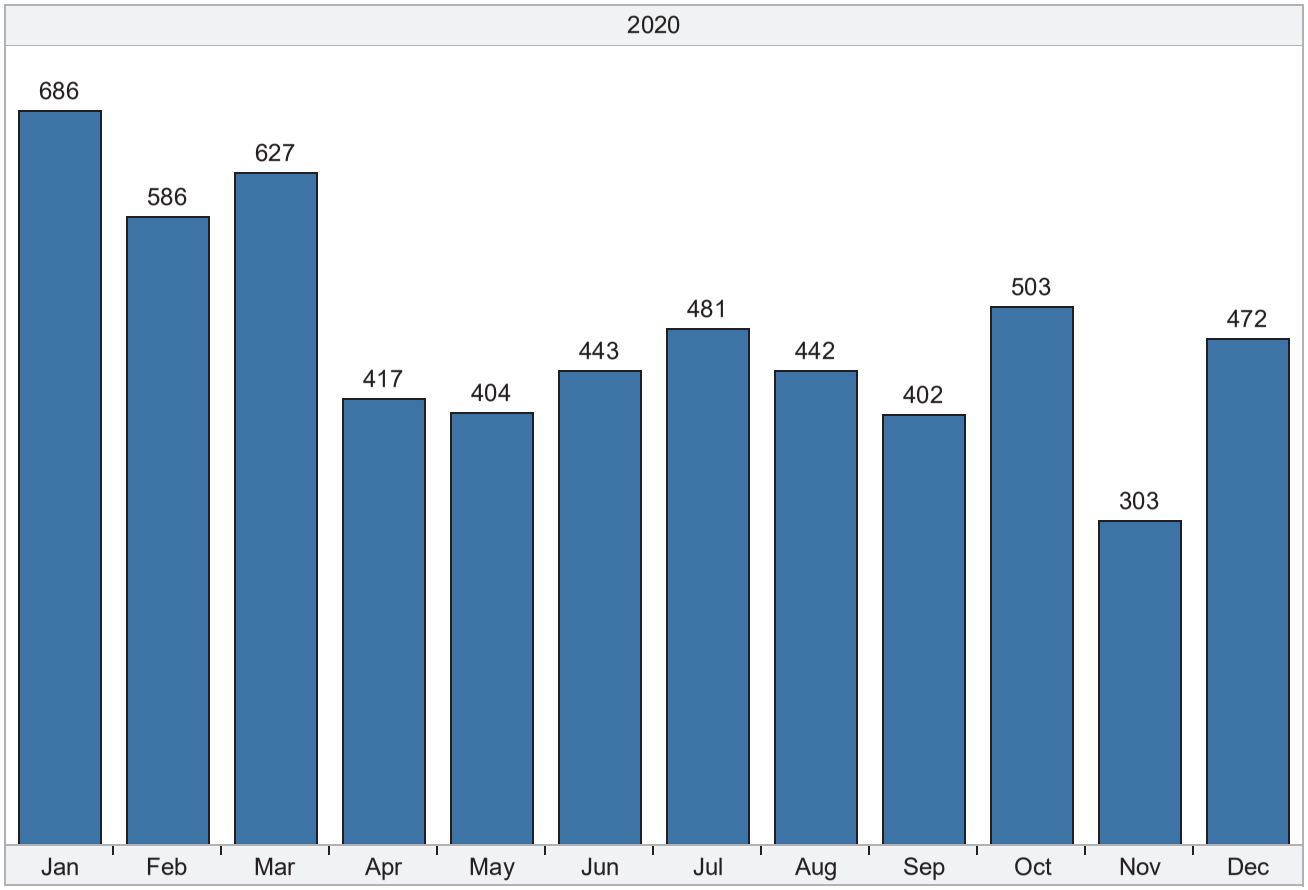
COB Requested?



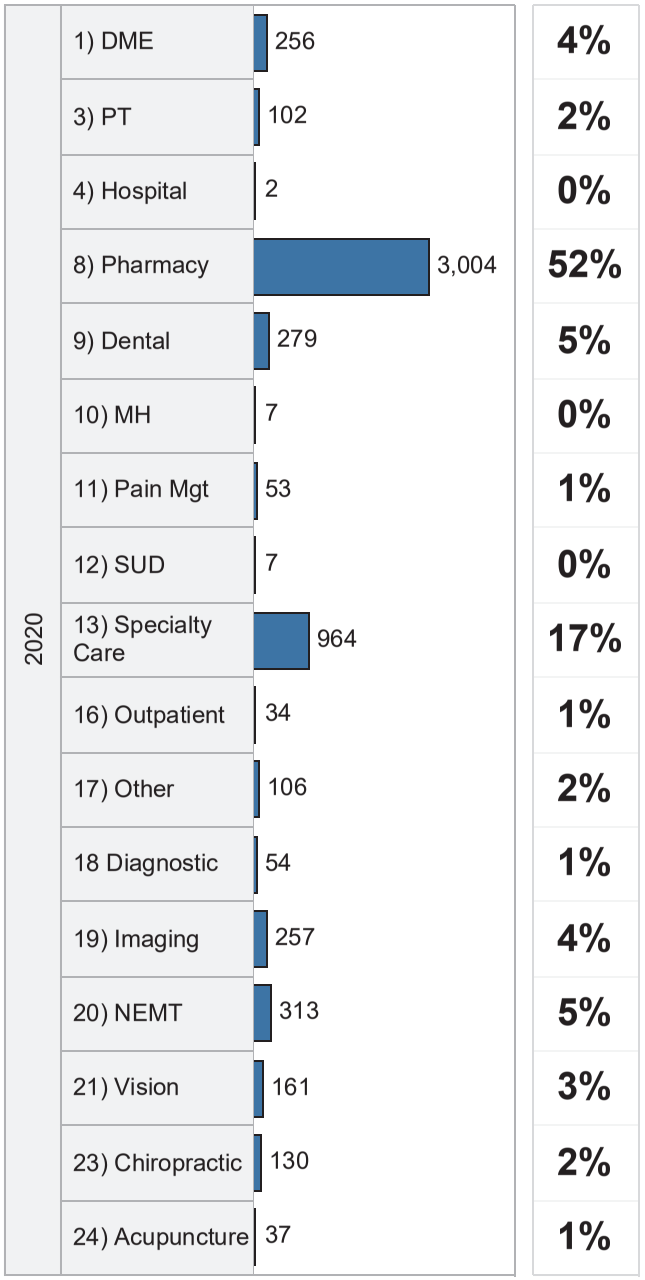
2020 DENIALS (NOABD) Feb 2021

Cascade Health Alliance

Denials by Quarter



Denials by Service Type



Average Determination (Days)

2020			
Q1	Q2	Q3	Q4
3.21	2.67	5.73	3.06

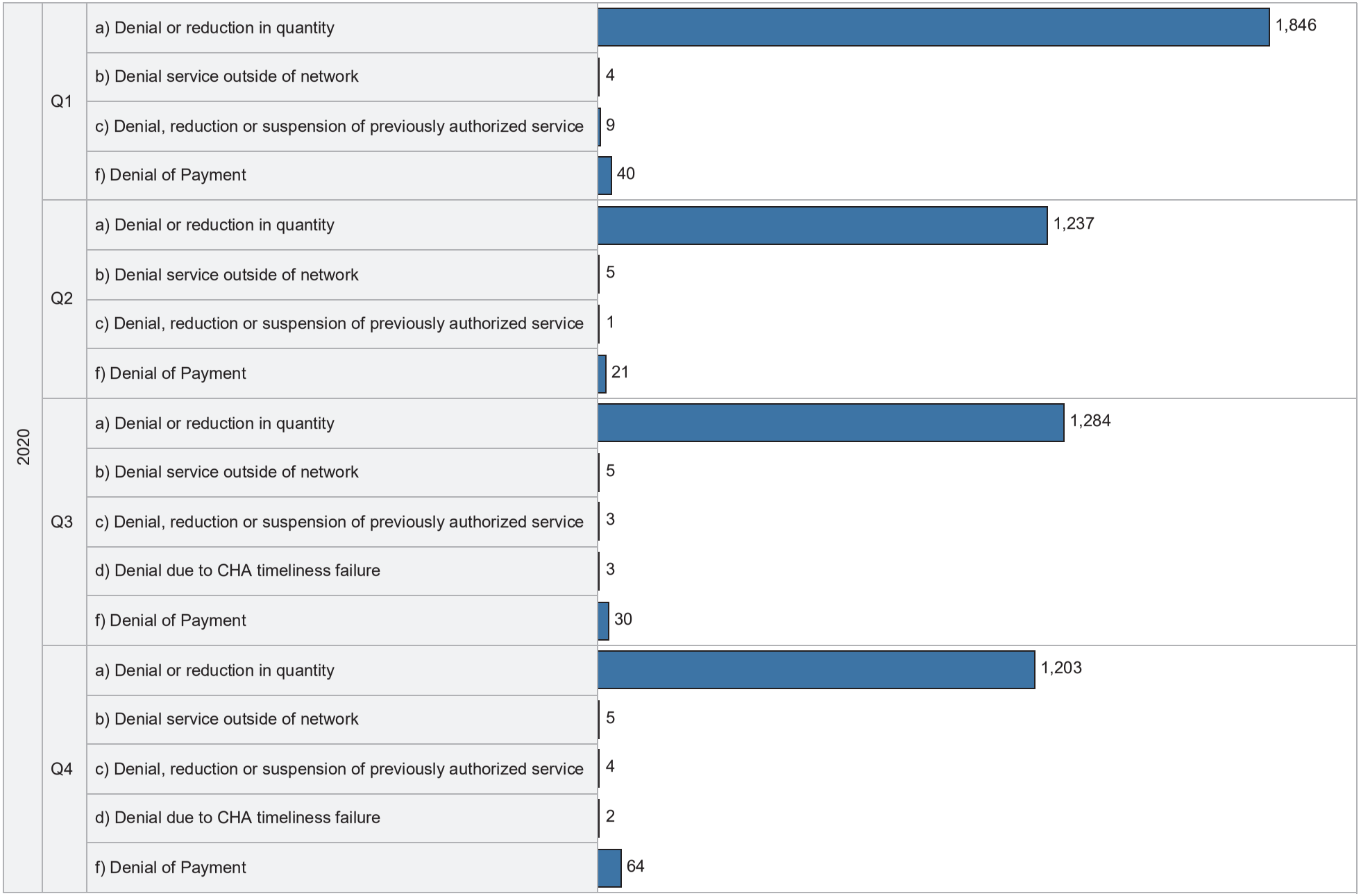
Denial Activity: 01/01/2020 - 12/31/2020 **Updated:** 02/12/2021 **Source:** [redacted] and Sky Lakes

Created Date: 02/16/2021
Created By: Danielle Sherman

2020 DENIALS (NOABD) Feb 2021

Cascade Health Alliance

Denials by Action Category



Denial Activity: 01/01/2020 - 12/31/2020 **Updated:** 02/12/2021 **Source:** [redacted] and Sky Lakes

Created Date: 02/16/2021
Created By: Danielle Sherman

2020 DENIALS (NOABD) Feb 2021

Cascade Health Alliance

Action Category

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- Requested a service that is determined by the MCE to be experimental, investigative, or not medicall necessary;
- Was/is not eligiblt for OHP at the time services were/are requested;
- Requested a service that is not a covered service; or
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b) Denial of a member's request to obtain services outside the managed care entity panel. Use this category when the MCE is denying a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network (42 CFR 438.400(b)(6).
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c) The reduction, suspension, or termination of a previously authorized service. 42 CFR §438.400(b)(2)
Explanation: When the MCE stops or decreases a service a member is already receiving, this is an ABD.

d) The failure of an MCE to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. 42 CFR §438.400(b)(5)
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Explanation: When a member has to wait longer than standard, urgent or emergency timeframes in the MCE Contract and OAR to get health care or receive a service, this is an ABD and the MCE must send the member an NOABD.

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Explanation: A member received a bill for services that they believe the MCE should have paid for, but didn't. If the MCE investigates and determines that the member signed an 'agreement to pay form' and the member is required to pay, the MCE must send the member a NOABD.

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3) The service is not medically appropriate
4) The service or item was received in an emergency care setting and does not qualify as an emergency service.
5) The Provider is not on the Contractor's panel and prior approval was not obtained (if such prior authorization would be required under OHP rules)

Grievances and Appeals

Grievances and Appeals

- Appeals of denied services can be filed by members within 60 days of denial notice (NOABD), must be in writing
- Expedited appeals & continuation of benefits (COB) may be requested
- COB requests must be made within 10 days of denial
- Appeal determinations made— 16 days
- Expedited & COB determinations— 72 hours
- CHA assists members in filing appeals upon request
- Grievances of any issue other than a denial can be filed by members anytime, verbally or in writing
- Grievance resolutions— 30 days (maximum)

Contested Case Hearings

- Members may request hearings if they **disagree** with the appeal determination
- OHA **requires** an appeal of the denied service be completed before hearing request
- Hearing requests **usually have to** be made within 120 days from the "Date of Notice" on the Notice of Appeal Resolution (NOAR)
  - Due to COVID-19, OHA is allowing an additional 120 days for these requests, total of 240 days from date of NOAR
- Hearings are **arranged by OHA** and occur 30 – 45 days from request
- Hearings are conducted by phone & determined by the Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH)
- Determinations are **not made** at the hearing but **are mailed** to members within 30 **days of hearing**

Provider Reconsiderations

- Provider **reconsideration** of denied services can be filed within 30 days of denial
- Cases can be **requested via peer-to-peer conversation** with Medical Director
  - Request through CHA Appeals & Grievances at (541) 851-2078
- Cases can be requested by letter, including **supporting documentation**, and **faxed** to CHA
  - Fax ATTN: Recons at (541) 882-6914
- Requests must be made by **provider**
- Reconsideration determinations – 30 Days
- Determination letters sent to **requesting provider** with **approved authorization** when **applicable**

Provider Dismissal of Member

- Pcp/pcds may terminate member care with due cause, as outlined in provider's policy
  - Examples: three or more "no show" appointments in 12 months, member abuse of provider or staff, member threats to provider or staff
- Dismissals must be initiated by provider, mailed to member, and copied to CHA via USPS mail, fax or email
  - Fax ATTN: compliance/dismissals at (541) 882-6914
  - Email: compliance@cascadecomp.Com
- CHA will not terminate member from care, but will reassign member upon receipt of dismissal

Provider Dismissal of Member cont.'

- Dismissal letters must reference reason for termination and effective date and direct member to contact CHA to be reassigned to another provider
- Dismissals must relate member will be seen by provider for 30 days from date of letter to allow for emergent care
- Members terminated from care can request clinical documentation be transferred to new provider
- Questions regarding dismissal/termination of care can be addressed to compliance@cascadecomp.Com

Example Provider Dismissal of Member Letter

DATE

ADDRESS
ADDRESS
ADDRESS

MEMBER ID#

Dear Member,

Effective DATE, CLINIC NAME will be unable to serve as your (Primary Care Provider/Primary Care Dentist/Dental Care Provider) under your Oregon Health Plan. (ENTER REASON IF APPLICABLE). We ask that you call Cascade Health Alliance Member Services at 541-883-2947 to be assigned to a new (Primary Care Dentist/Dental Care Provider).

Our office will continue to be available to you for emergency care for a period of up to 30 days while you are seeking other (Primary Care/Primary Dental Care) services.

If you wish to have copies of your care records and x-rays, please contact our office CONTACT INFO to let us know the new (Primary Care Provider/Primary Dental Care Provider) that will be providing your care.

If you have any questions about this letter, please call CHA Member Services at 541-883-2947.

Sincerely,

NAME/CLINIC/Manager

Klamath Basin Oral Health Coalition Work Plan

OHA Closed Project #60

Priority Area: **Oral Health**

Goal: Improve access to and awareness of oral health services.

Benchmark: 65% of the adult population in Oregon have visited a dentist in the past year (2017 Oregon State Dental Visits)

				Quarterly Tracking				
Objective 1:	**Increase percentage of adults visiting dentists each year to 70%.**		**Process Measure**	**Oct-Dec 2019**	**Jan-Mar 2020**	**Apr-June 2020**	**July-Sept 2020**	**Process Target**
	Strategy 1.1.	Develop a coordinated dental services referral protocol.						
	Task 1.1.1.	Talk with PCPs about oral health and diagnosis - develop a 1-page "hit list" for oral matters and diabetes	1-pager developed	Not yet started	Not yet started	Developed and finalized brochure on oral care for patients with diabetes	English and Spanish versions distributed to the coalition. Completed.	1-pager developed and distributed among clinics
	Task 1.1.2.	Pilot a program where a hygienist could follow-up with diabetics, newly diagnosed patients.	Pilot program created; pilot cohort recruited	Not yet started	Not yet started	KHP hired a new dental director who is interested in starting a physical-dental integrated program. Patients with diabetes is the suggested beginning population.	No activities this quarter. Will continue project in Year 2.	Pilot cohort recruited and implementation plan developed
	Task 1.1.3.	Create a follow-up loop/auto referral to CHWs and oral health for all newly diagnosed diabetic patients	Follow-up loop created; process piloted with CHWs	Not yet started	Not yet started	Not yet started.	Task will begin in Year 2 workplan.	CHW piloted, analysis completed
	Strategy 1.2:	Train Frontline healthcare workers (FLHW) on oral health intake, visual screening, referral, and patient education.						
	Task 1.2.1.	Train DHS Family Coaches.		OHSU Nursing students trained 9 DHS family coaches on oral health curriculum--this task is complete	No additional family coaches trained in this quarter--task complete	No additional family coaches trained in this quarter--task complete	No additional family coaches trained in this quarter--task complete.	All family coaches trained (9 as of December 2019).
	Task 1.2.2.	Expand FLHW training to local CHWs, case managers, navigators.	# trainings held; # participants at each training	OHSU nursing students are placed in BestCare for winter term 2020 to train 12 staff on substance abuse-specific dental care. Ongoing work with DHS family coaches.	2 dental hygiene and nursing teams screened 31 BestCare residents, gave ed. pres. to BestCare staff.	Relationship fostered by OHSU Nursing between BestCare and OIT Dental Hygiene; planning for 4-term DH community health project at BestCare	No activity this quarter (summer term, students off). Project will continue in Fall 2020 (year 2 workplan).	All CHWs trained. 50% of FLHWs trained
	Strategy 1.3:	Incorporate dental screening, referral, and treatment into local hospital.						
	Task 1.3.1.	Research Linn-Benton OHC and hospital oral health program.	Analysis and overview of program; contact LBOHC "staff"	SLMC OPCM staff reported on ORH conference break-out session on model hospital dental program	No activities this quarter	No activities this quarter	Task will begin with Year 2 workplan.	Contact made; sharing of program and plan created for KBOHC
	Task 1.3.2.	Create a work group to develop a pilot program for oral health services in hospital.	Work group formed	Not yet started	Not yet started	Not yet started	Not yet started	Pilot program and implementation plan
Objective 2:	**Increase awareness of relationship between oral health and physical health shown through increase in preventative service utilization (5% increase)**		**Process Measure**	**Oct-Dec 2019**	**Jan-Mar 2020**	**Apr-June 2020**	**July-Sept 2020**	
	Strategy 2.1.	Increase awareness of relationship between oral cancer and physical health.						
	Task 2.1.1.	Develop materials with KBOHC branding to have available at events (banner eventually).	Co-branded materials developed.	Work group preparing application for grant to fund design, translation, printing of ed./promo materials	KHP applied for the West Family Foundation grant for promo/ed materials	KCPH/OIT DH: Planning for brochure on head and neck cancer self-exams and HPV vax/tobacco cessation card for dental take-home bags; West grant decision delayed due to COVID-19	The coalition's logo was redesigned to give it a more professional look. Coalition will continue in Year 2 to develop branded materials.	Materials developed.
	Task 2.1.2.	Staff community events with KBOHC events.	# events participated in	Health Fair in March, Free Dental days in April, Community Baby Shower on Oct. 5	Health Fair and KBOHC Free Dental Days postponed due to COVID-19, planning continues for Community Baby Shower in Oct.	Planning continued for Community Baby Shower in October	Planning for the Community Baby Shower, with organizers shifting to a drive-by model. OIT DH is planning to participate in the Merrill Potato Festival Health Fair.	Participate in Health Fair and Senior Health Fair.
	Task 2.1.3.	Expand community outreach plan and update calendar.	Expanded outreach calendar; outreach/ communication plan	Communication plan shared	Yearly outreach calendar updated and shared with coalition	Coalition discussed Communication Plan; planning for updates to Research, Audiences and Comm. Channels.	Communication plan upated	Updated communication plan.
	Task 2.1.4.	Support OIT Knight Cancer CPP grant in conducting oral cancer education needs assessment among providers.	Needs assessment completed.	~70% participation rate on needs assessment survey, 12 in-depth interviews completed.	OIT Dental Hygiene Dept. finished interviews and sent gift cards to survey participants	OIT Dental Hygiene and Population Health Management worked on the data analysis and final report	CPP needs assessment completed, final project accepted.	Needs assessment completed.
	Strategy 2.2.	Increase annual oral health evaluations for adults with diabetes to 30%.						
	Task 2.2.1.	Use case management/care coordination to schedule and follow up with diabetic clients about oral health.	Increase in # of oral evaluations among patients with diabetes	Discussions with CHWs at several diabetes self-mgmt programs about current dental care info for diabetic patients	No activities this quarter	No activities this quarter	No activities this quarter. Project will be highlight of year 2 workplan.	Oral evaluations for diabetic patients increased to 30%
	Task 2.2.2.	Work with CHA diabetic education to provide education materials to clients. Develop education tool for diabetics with dentures.	Survey and tool developed for patients with diabetes who have dentures		No activities this quarter	Coalition designed a brochure on denture care for patients with diabetes; nearing finalization	Brochure distributed to coalition in English and Spanish versions	Education provided to all CHA diabetic patients with dentures.

		Task 2.2.3.	Work with OCM and KHP to develop diabetic outreach and implant oral health education.	Oral health curriculum included in diabetes education/programming	OCM intake forms have been updated to include oral health questions and dental care plans developed in pilot with CEFM). Smiles for Life curriculum training hosted for new CHWs	All patients assessed for access to dental care provider, additional dental health for diabetic patients.	During pandemic OCM continued to provide patient education via telephone, assess for SDoH including food insecurity and dental access.	KHP's CHW program began recruiting patients in late September 2020. Oral health education will be incorporated in CHW care plans beginning in Oct 2020 (year 2 workplan).	3- or 6-month post-training survey results show 75% of those trained use information learned daily
Objective 3:	**Increase percentage of pregnant women seen by dentist during pregnancy to 35%.**			**Process Measure**	**Oct-Dec 2019**	**Jan-Mar 2020**	**Apr-June 2020**	**July-Sept 2020**	
	Strategy 3.1.	Develop education materials for providers about safe and appropriate procedures.							
		Task 3.1.1.	Work with OBs and dentists to develop appropriate materials for interdisciplinary communication.	Materials developed and distributed	KCPH: Dental recommendations obtained from Dr. Cory Johnson; initial planning of infographics targeting dentists	KCPH: additional planning of brochure for dentists	Dr. Williams of KHP and Dr. Johnson of Applewood co-authored and finalized an oral health during pregnancy brochure for dentists. Electronic file distributed to KBOHC, Applewood	Completed.	Materials distributed among clinics.
		Task 3.1.2.	Create work group to create/find appropriate materials for patient/community education.	Work group formed	Not yet started	Work group formed to discuss pregnant patient oral health ed needs	KCPH designed a brochure on oral health for pregnant moms, KBOHC approved it. Electronic file distributed to coalition and Pregnancy Hope Center. CHA will use brochure in incentive program.	Completed.	Materials distributed among clinics.
		Task 3.1.3.	Educate mothers on the importance of oral health through WIC and community dental screenings	Survey distribution	No activites.	No activities.	OIT Dental Hygiene's Community Health Lead administered 11 surveys to mothers on oral health behaviors and perceptions at WIC during [redacted] screenings as part of a Masters research project.Follow-up will be implemented by Oregon Tech Dental hygiene students.	Planning for monthly education with WIC clients, as well as a new nutritional option to include activities such as food label reading	Administration of surveys and interviews. Understanding of mothers' knowledge of oral health practices.
	Strategy 3.2.	Develop education materials for pregnant women.							
		Task 3.2.1.	Work with CCO, providers, KCPH to create materials for pregnant women about the benefits of good oral health during pregnancy	Materials created and # distributed by program	Not yet started. Design and printing quotes pending.	KCPH began design of a Title V-themed infographic for pregnant women, including encouragement to see dentist	Work group review of KCPH Title V health tips for pregnant moms poster and social media posts.	"Health Tips for Pregnant Moms" poster distributed to infant mortality work group in English and Spanish; tips included as flyer in the Direct On-Scene Education (DOSE) program envelope.	Materials created and # distributed by program
	Strategy 3.3.	Develop shared protocol among obstetricians and dental providers about referral and communication between specialties.							
		Task 3.3.1.	Work with CCO and other providers to expedite and improve the number of pregnant women seeing dental providers.	Increase in # of pregnant women seen by dental providers	CHA reached out to PCP & OB providers about pregnant women seeing a dentist during their pregnancy. CHA is compiling data on preventive dental services for pregnant members.	CHA continued to work with OB offices, PCP and dental offices to request expedited services.	CHA worked with OB offices, PCP & dental offices to request expedited services when they were there. Dental offices closed for several weeks during the coronavirus shutdown. Only one (2.5%) pregnant CHA member had a preventive dental visit during this period. Over 775 (3.6%) of CHA patients had a PDV in this period.	No pregnant CHA members had a preventive dental visit during this period. Of CHA patients, 1294 (5.9%) had a PDV in this period.	35% of pregnant women see their dentist at least once during pregnancy
Objective 4:	**Research and support at least two oral health policies or initiatives per year.**			**Process Measure**	**Oct-Dec 2019**	**Jan-Mar 2020**	**Apr-June 2020**	**July-Sept 2020**	
	Strategy 4.1.	Join Oral Health Progress and Equity Network (OPEN).							
		Task 4.1.1.	Support oral health policies or initiatives as notified through OPEN	# of policies supported/letters created	Letters sent to 2 Oregon senators in support of dental benefits in Medicare.	KBOHC endorsed Healthy Teeth Bright Futures campaign through Oregon Community Foundation. KBOHC became a member of OCF's Pediatric Oral Health Coalition.	KBOHC signed onto a letter sent by OPEN to US congressional leaders asking they include policies supportive of oral health in next COVID-19 relief package. Sent copies to state senators and rep.	Coalition endorsed the Healthy Teeth Bright Futures letter to policymakers regarding oral health and the coming Oregon budget rebalance	At least two policies supported.
	Strategy 4.2.	Secure funding for research and policy health impact assessment.							
		Task 4.2.1.	Research grant opportunities (OIT search engine)	# grants found/# grants applied for	KCPH researched grant opportunities at OIT, 5 found, preparing 1 grant application.	KHP applied for the West Family Foundation grant for oral health promo/ed materials.	Communicated continued intention to apply for grant with West Family Foundation during COVID-19 pandemic	The West Family Foundation abandoned the Spring 2020 grant cycle. They will instead provide assistance those displaced by wildfires in southern Oregon. Task 2.1.1.	At least two grants are applied for.
		Task 4.2.2.	Apply for a grant and/or work with community partners to house an intern/staff for impact assessment.	# grants applied for	KCPH/KHP applied for OHSU Campus for Rural Health graduate student for HIA on water fluoridation, did not receive; continuing discussions with CRH staff	KBOHC connected with OHSU Rural Campus to conduct a literature review and funding review regarding impact assessment. KBOHC will consider an intern post-COVID-19	No activities this quarter. KBOHC has partnered with OSHU Rural Campus and local Community Research Hub through Healthy Klamath. KBOHC is creating an intern "position description" to post with OHSU in year 2 of workplan.	No activities this quarter.	Impact assessment planned and researcher identified
	Strategy 4.3.	Recruit intern or student to research policies and impact on oral health.							

	Task 4.3.1. Conduct impact assessment	Student/intern "hired". Impact assessment and meta-analysis complete.	See Task 4.2.2 above	See Task 4.2.2.	See Task 4.2.2	See Task 4.2.2	Impact assessment planned and researcher identified

Tell us about the progress you made towards your objectives

Oct-Dec 2019	Progress was made on the majority of work plan objectives through extensive interagency efforts. Significant work was completed in relation to oral health training of CHWs, head and neck cancer screenings, oral care for pregnant women, and efforts to secure grant funding/interns for health impact assessments and/or promotional materials. In 2019, the rate of preventative dental among pregnant patients increased 3.4% compared to 2018, with all CHA members increasing almost 1%.
Jan-Mar 2020	During this quarter the coalition continued to make progress on a majority of objectives, including Oregon Tech Dental Hygiene's Knight grant, outreach to pregnant moms and diabetics, and expanded training of FLHWs on the Smiles for Life curriculum. Extensive planning went into the Free Dental Clinic Days, which were ultimately postponed due to COVID-19. 11.7% of CHA patients with diabetes had an oral health assessment within the past year as of Q1 2020 and 9.4% of CHA patients had a prevenative dental visit in the quarter. Only 6.2% of patients with diabetes had both a cleaning and oral evaluation as of the end of the quarter.
Apr-Jun 2020	Despite the coronavirus closures, the coalition continued to hold virtual meetings each month and made progress on a large majority of work plan objectives. Almost 4% of CHA members had a preventive dental visit between April-June 2020. Nearly 5% (25) of patients with diabetes have had an oral assessment in 2020. OIT faculty, Liz Wells, saw success in her project working with pregnant mothers and new moms (those enrolled in WIC) in collecting data around oral health education and uptake.
Jul-Sep 2020	This quarter saw the continuation and completion of numerous projects, such as the development and printing of educational brochures and flyers, the Knight CPP grant project, and the OIT Dental Hygiene Community Health project in collaboration with WIC. In the midst of the pandemic, plans for community outreach events continued; public health guidelines will be closely observed. 5.9% of CHA patients had a preventive dental visit in the quarter. Only 0.9% of patients with diabetes had both a cleaning and oral evaluation during the quarter, which would appear to indicate that this population is hesitant to venture out to see the dentist during the pandemic.

Tell us about any barriers you encountered and contributing factors. What do you plan to do to address them?

Oct-Dec 2019	Some of the DHS Family Coaches encountered some resistance among the families to discussing oral health. Another barrier was assessing whether or not a change in behavior of clients toward oral health practices occurred; a follow-up survey of family coaches is planned for Feb. 2020. The Knight Cancer Institute grant encountered low participation with their online survey; this was overcome by hand delivering paper surveys to dental offices. Interview participation was accomplished through snowball networking among dentists and dental hygienists.
Jan-Mar 2020	The COVID-19 outbreak brought many of the coalition's activities to a standstill in mid- to late March. On March 18, Oregon Governor Kate Brown announced an executive order directing Oregon's higher education institutions to move their curriculum to online learning, prohibiting in-person classroom interactions, which affected Oregon Tech Dental Hygiene's Department and OHSU's School of Nursing Program. Medical and dental offices were ordered to close except for emergency procedures on March 20 in order to ensure patient safety and conserve personal protective equipment for the coronavirus response. On March 23, the governor issued a statewide stay-at-home order. With these social distancing measures in place, the group scrambled to find a way to continue its work. Despite having the majority of preparations already in place, the coalition decided to postpone the Free Dental Clinic Days planned for April 25 and 26 in Malin and Merrill. In order to address these barriers, the coalition will meet virtually until given authorization to hold in-person meetings again. Case managers continue to provide patient education via telephone, assessing patients for social determinants of health, and assisting with outreach to other partner agencies. With severely limited opportunities for in-person dental patient interventions, the group will work on projects behind the scenes, such as the development of a series of educational materials on oral care for specific vulnerable populations. Preparations for the Community Baby Shower, as well as rescheduling the postponed Free Dental Clinic Days, will evolve in response to public health recommendations.
Apr-Jun 2020	The coronavirus pandemic continued to be a barrier to oral health work as many offices were open for emergency services only while the stay-at-home order was in place. Dental and other health care offices began the process of reopening while observing strict requirements around for distancing, PPE, screening for symptoms, etc. Reduced hours and remote work by PCP and OB office staff made the process of expediting oral health services more challenging. CHA and OCM connected with clients by phone.
Jul-Sep 2020	After submitting an application in February for a West Family Foundation grant to fund the design and printing of educational and promotional materials, the Foundation ultimately abandoned the Spring 2020 grant cycle in order to provide assistance to those affected by southern Oregon wildfires. We hope to apply again next spring. Oregon Tech Dental Hygiene's Community Health lead experienced difficulty reaching mothers at WIC for her master's project due to COVID-19 restrictions; she shifted to a mail-in survey. Despite relatively low participation in the study due to these challenges, the project was completed and planning continued between Dental Hygiene and WIC for oral health education of parents. Diabetic patients on the Oregon Health Plan had low rates of preventive dental visits in comparison to recent quarters; this underscores the need for effective communication with this population about the importance of visiting the dentist, and COVID-19 precautions that dental providers have in place.

Tell us about a success you had and contributing factors.

Oct-Dec 2019	OIT Dental Hygiene's Knight Cancer Institute grant-funded needs assessment on head and neck cancer assessments among dentists and dental hygienists had a 65% survey response rate and completion of 6 in-depth interviews. OHSU School of Nursing's training of 9 DHS Family Coaches as frontline health coaches was an example of successful interagency collaboration.
Jan-Mar 2020	Extensive planning went into the Free Dental Clinic Days which were to be hosted in April 2020; Coalition partners were successful in gathering data for Oregon Tech Dental Hygiene's Knight grant and expanding and continuing training FLHWs in the Smiles for Life.
Apr-Jun 2020	OHSU School of Nursing helped foster a relationship between Oregon Tech's Dental Hygiene Program and BestCare; as a result BestCare will be a four-term community health project for the Dental Hygiene Program. KCPH/KBOHC designed two brochures on oral health during pregnancy, and two on preventive oral care for patients with diabetes; the coalition has reviewed all four brochures and finalized three.
Jul-Sep 2020	Oregon Tech completed their OHSU Knight Cancer Institute Community Partnership Program grant-funded needs assessment, with their final report submitted and accepted. Preparations continued for the Community Baby Shower to be held in October, with organizers shifting to a drive-by model in order to observe COVID-19 precautions.

OHA PIP Progress Report

PIP Title: Preventative Oral Health Care at All Ages

CCO: Cascade Health Alliance

QI Lead: Susan Boldt

QI Contact email: susanb@cascadecomp.com

Measurement Year 2020 ☐ **Quarter 1** ☐ **Quarter 2** ✓ **Quarter 3** ☐ **Quarter 4**

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Continue to practice good oral hygiene.

AFTER YOUR BABY IS BORN

Keep up the good work!

- Keep visiting the dentist and practicing good oral care.
- Try to breastfeed for at least 4 months, ideally for 6 months.
- Feed your baby healthy foods.
- Take care of your baby's gums and teeth.
- Ask your pediatrician to check your baby's mouth starting at 6 months.
- Take your baby to the dentist by age 1.

Source:
Oral Health Care During Pregnancy Expert Workgroup. 2012. *Oral Health Care During Pregnancy: A National Consensus Statement.* Washington, DC: National Maternal and Child Oral Health Resource Center.

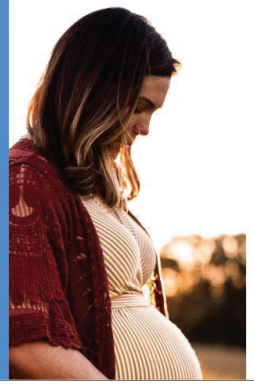
Klamath Basin Oral Health Coalition
Improving the oral health of our community members!

Cascade Health Alliance, LLC

May 2020

Klamath Basin Oral Health Coalition

VISITING THE DENTIST DURING PREGNANCY is safe and important



It's safe and important.

Visiting the dentist will keep you and your baby healthy.

Taking care of your mouth while you are pregnant is important for you and your baby.

During pregnancy, your gums can get sore or puffy and bleed (gingivitis). Untreated gingivitis can lead to gum disease and tooth loss.

Putting off necessary treatment could result in significant risk to you and your baby (for example, a bad tooth infection in your mouth could spread throughout your body).

Get oral health care.

Schedule a dental appointment as soon as possible.

Tell the dental office that you are pregnant and your due date.

Get oral health treatment **before delivery**.

Oral health care, including x-rays, pain medication and local anesthesia, are **safe** throughout pregnancy under the direction of your dentist and OB/GYN.

Eat healthy foods.

- Eat a variety of healthy foods, such as fruits, vegetables, whole grains, legumes, beans and nuts.
- Drink water throughout the day.
- Choose foods low in sugar.

Practice good oral hygiene.

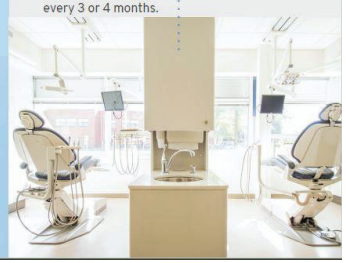
Brush twice a day with fluoridated toothpaste.

If you vomit, rinse your mouth with a teaspoon of baking soda in a cup of water.

Use floss or an interdental cleaner daily.

Use xylitol-containing gum or mints after meals.

Replace your toothbrush every 3 or 4 months.



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Sigue practicando buena higiene bucal.

DESPUÉS DE DAR A LUZ

¡Sigue adelante!

- Acude a tu dentista y practica una buena higiene bucal.
- Intenta dar pecho por lo menos 4 meses, e idealmente por 6 meses.
- Da de comer a tu bebé alimentos saludables.
- Cuida las encías y dientes de tu bebé.
- Pídele a tu pediatra que revise la boca de tu bebé empezando a los 6 meses de edad.
- Lleva a tu bebé al dentista antes de que cumpla un año.

Fuente de información:
Oral Health Care During Pregnancy Expert Workgroup. 2012. *Oral Health Care During Pregnancy: A National Consensus Statement.* Washington, DC: National Maternal and Child Oral Health Resource Center.

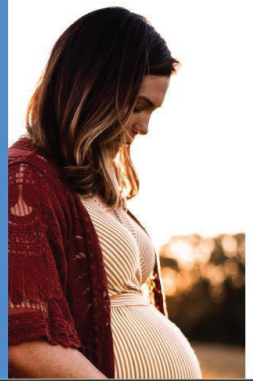
Klamath Basin Oral Health Coalition
Improving the oral health of our community members!

Cascade Health Alliance, LLC

May 2020

Klamath Basin Oral Health Coalition

ACUDE A TU DENTISTA DURANTE TU EMBARAZO: Es seguro e importante



Es seguro e importante.

Acudir al dentista mantendrá saludables a ti y a tu bebé.

Cuidar tu salud dental durante el embarazo es importante para ti y tu bebé.

Durante el embarazo tus encías pueden ponerse adoloridas o inflamadas y sangrar (la gingivitis). La gingivitis sin tratamiento puede ocasionar la periodontitis (enfermedad de las encías).

Posponer el tratamiento necesario puede resultar en un riesgo significativo para ti y tu bebé (p.ej. una mala infección en tu boca podría extenderse por todo tu cuerpo).

Acude a tu dentista.

Haz una cita con tu dentista lo antes posible.

Avisa al consultorio dental que estás embarazada, y la fecha de alivio.

Busca atención dental **antes de dar a luz.**

La atención dental, incluyendo los rayos X, analgésicos y la anestesia local son **seguros** durante el embarazo bajo la supervisión de tu dentista y ginecólogo/a.

Come alimentos saludables.

- Come una variedad de alimentos saludables, tales como frutas, vegetales, granos integrales, leguminosos, frijoles y nueces.
- Toma agua durante el día.
- Elige alimentos bajo en azúcar.

Practica una buena higiene bucal.

Cepíllate los dientes dos veces al día con una pasta que contenga flúor.

Si vomitas, enjuágate la boca con una cucharadita de bicarbonato en una taza de agua.

Usa el hilo dental o un limpiador interdental diario.

Usa chicle o mentas que contengan xilitol depués de cada comida.

Reemplaza tu cepillo de dientes cada 3 ó 4 meses.

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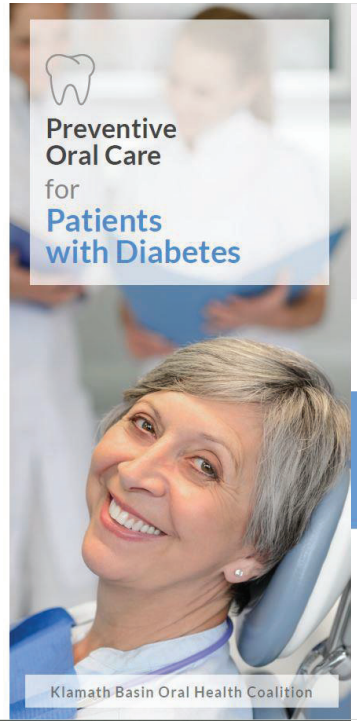
References
and Other Resources

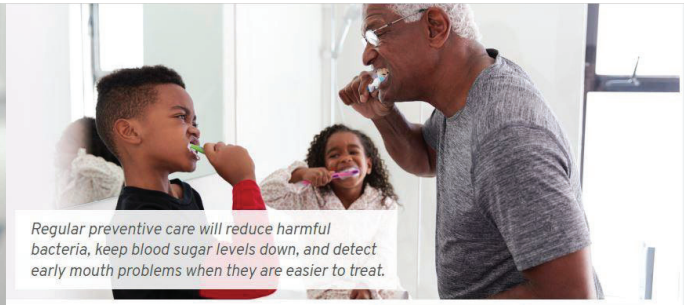
American Dental Association
www.ada.org

National Institute of Diabetes and Digestive Kidney Diseases
www.niddk.nih.gov

Mayo Clinic
www.mayoclinic.org

Klamath Basin ORAL HEALTH COALITION





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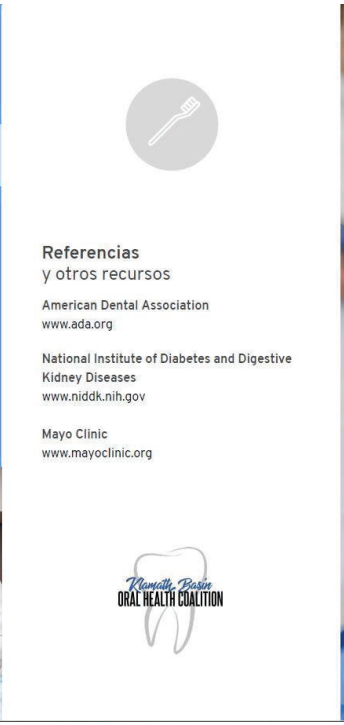

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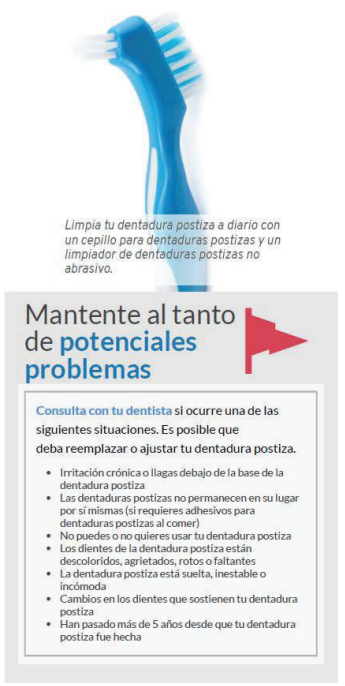
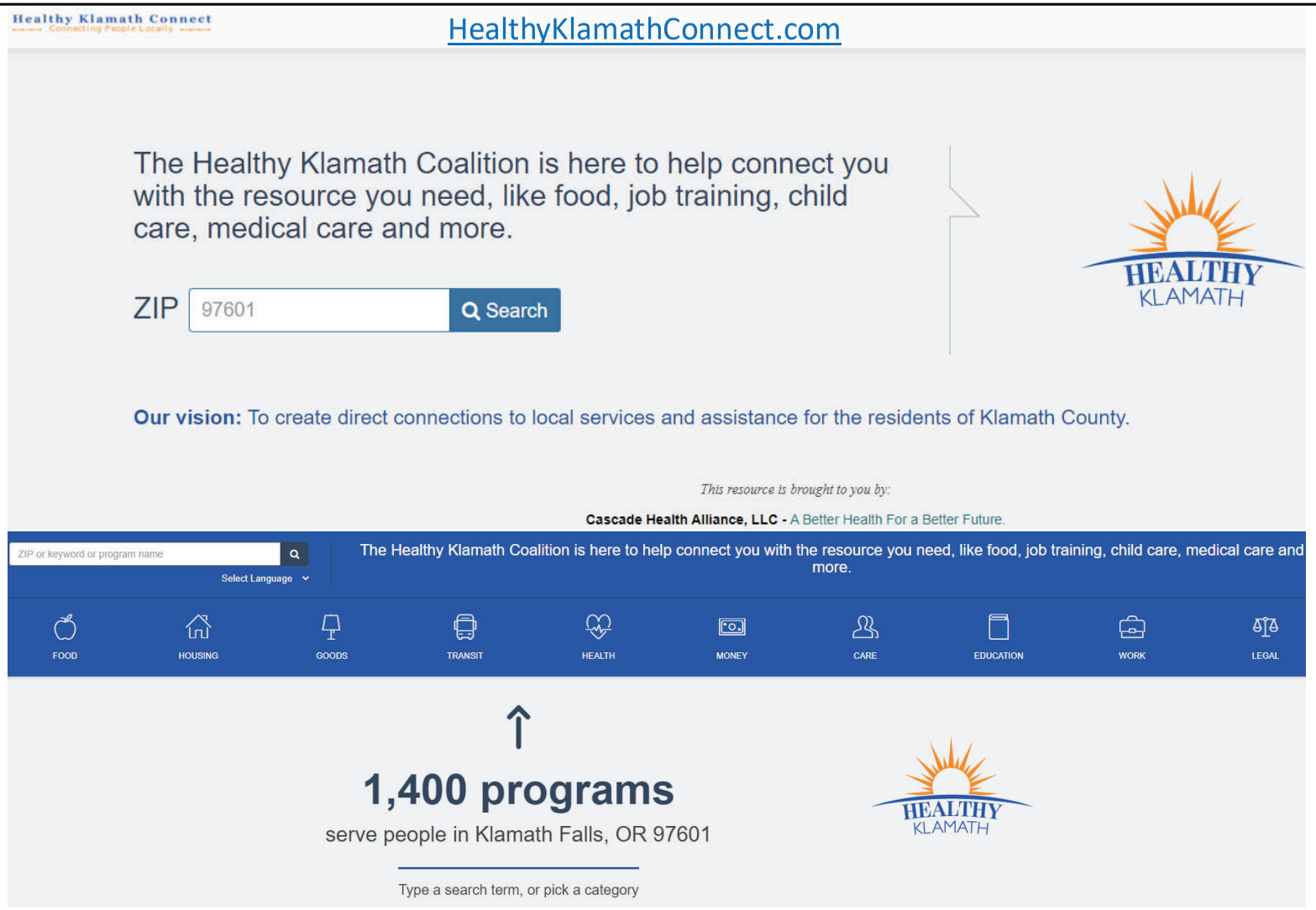


Healthy Klamath Connect

Provider Training: Community Information Exchange



Oregon Health Authority

Community Information Exchange (CIE) Opportunity for LPHAs, COVID-19 CBO Grantees & Tribes

CIE systems are available in most regions of Oregon. Local public health authorities (LPHAs), COVID-19 Community-Based Organization (CBO) Grantees, and Tribes can access these systems and training at **NO COST**.

What is a CIE?

Community Information Exchanges (CIEs) help groups like yours connect Oregonians to social services and supports by electronically connecting health care, human and social service partners. CIE uses a technology system for a shared resource directory, "closed-loop" referrals, reporting, and optional social needs screening and case management.

Who is this opportunity for?

Participation is voluntary and not an OHA requirement.

- ✓ LPHAs, CBOs, & Tribes referring for or providing COVID-19 wraparound and social service supports to safely isolate or quarantine
- ✓ Other CBOs assisting those affected by COVID-19

How can CIE help with COVID-19 and beyond?

- Efficiently search available resources, track referrals, and “close the loop”
- Simplify processes for connecting people with benefits and other resource organizations
- More seamlessly track and report data for grants and other requirements

Where is Community Information Exchange (CIE) Available?

Communities, CBOs, clinics, and Oregon Health Plans (Medicaid Coordinated Care Organizations (CCOs)) are participating in CIE across Oregon, with two main CIE vendors: Aunt Bertha and Unite Us/Connect Oregon.

Where Aunt Bertha CIE is available:

Aunt Bertha has free tools available across Oregon for CBOs, LPHAs, and Tribes and is working with Medicaid CCOs and Health Plans: Cascade Health Alliance and Trillium Community Health Plan in these counties:

- Clackamas
- Klamath
- Lane
- Multnomah
- Washington
- Statewide tools


aunt bertha
Free Tools for Community Organizations
Claiming Your Program
Get access to your programs!
Go to www.auntbertha.com/claims.
Enter the name of your program or organization, then click "Search."
Select the program(s) you'd like to claim and click the "Claim" button.
Create an account by entering your name, work email, and password.
Suggest a Program
Not seeing your program?
Go to www.auntbertha.com/find_a_program.
Search and verify your program isn't listed.
Fill out the section titled "Review the program you searched for."
Click the "Suggest a Program" button at the bottom of your screen.
You should hear from us within two business days!

My Program Tools

Once you're logged into your Aunt Bertha account, navigate to the top right corner and locate "My Program Tools."

This menu is your central navigation. You have access to all your tools, reporting, and editing capabilities from here!

Program Analytics

- **Screener Dashboard**: Review reporting on screening form. (This must be enabled before use.)
- **My Activity Dashboard**: See an overview of your search activity.
- **Claimed Program Dashboard**: Find search trends and inbound referral statistics on your claimed programs.

Inbound Referrals

- Go to "My Program Tools" > "Inbound Referrals."
- Click the folder of the program with a new referral.
- View the details of the person reaching out.
- Update the status of each referral. (This translates to your program analytics.)

- **Have you claimed your programs on Aunt Bertha?**
  www.auntbertha.com/claims

aunt bertha

Edit Your Program Listings

In "Edit Contact Settings," you can make changes and updates to programs; hours and locations; and contact information.

Make sure there is an email address in the second box labeled "What address should we send their info to?" This email address only gets notifications from Aunt Bertha letting your program know someone has reached out. It is NOT visible in public search.

Screening Form

Go to "Edit Program Listings."

- Click "Edit Contact Settings"
- Select "Customized Screening Form" button.

You'll be able to create and customize your screening form, with over 80 standard questions available to help you get started!

Scheduler

Go to "Edit Program Listings."

- Click "Edit Contact Settings" for the program you wish to update.
- Select "Intake Scheduler"

An Aunt Bertha team member will help you configure this tool.

- Set custom availability for individual team members.
- People in need can book appointments directly from Aunt Bertha.
- The Scheduler includes Google Calendar and Outlook integrations.

SEMGLEE

Cascade Health Alliance has a new preferred basal insulin. Meet Semglee.

The FDA has yet to classify Semglee as “biosimilar” or “interchangeable” to Lantus due to the need for additional review – so for now, Semglee should be considered a new basal insulin option for people with diabetes.

Semglee (insulin glargine) gained FDA approval on June 11, 2020 based on a comprehensive analytical, preclinical, and clinical program review which confirmed the pharmacokinetic and pharmacodynamic efficacy, safety, and immunogenicity in comparison to Lantus in patients with Type 1 and Type 2 diabetes.

The dosing for Semglee is identical to Basaglar and Lantus that is currently used to manage your patients.

A Prior Authorization will be required for Basaglar insulin effective **December 1, 2020**

Please issue a new prescription for Semglee for CHA patients currently on Lantus or Basaglar to ensure uninterrupted coverage.

Cascade Health Alliance Diabetes Project Preliminary Readiness Activities Summary
TQS: Special Health Care Needs

Change Management Process (CMP) Summary: Improving Diabetes HbA1C Control through SDOH Screening and CIE			
Date: Q1 2021			
Activity	**Description**	**Activity used in this project?**	
Project Determination Grid	Evaluate the viability of the project and areas of alignment with other projects and contract requirements.	Yes	
Root Cause Analysis, Fishbone Diagram, Five Whys	Problem solving method that identifies nonconformant factors that should be eliminated by process improvement. Steps include: define the problem, collect data, identify possible causal factors, identify the root causes, recommend and implement solutions	Yes	
SWOT Analysis	A strategic planning technique to identify an organization's strengths, weaknesses, opportunities, and threats. It is used to build on what you do well, address what you are lacking, minimize risks, and take the greatest possible advantage of chances for success. Internal and external factors, current and future potential.	Yes	
Stakeholder Analysis	Evaluate key stakeholders current levels of support for project and the level of support needed from key stakeholders to move project forward.	Yes	
Resistance Analysis	Evaluate types of resistance that may be encountered with project. Types of Resistance: technical (factual), political (threats to Authority), cultural (norms), and individual (personal).	Yes	
Attitude and Influence	Evaluate key stakeholders attitude and amount of influence for project.	Yes	
3 D's	Understand data, demonstration, and demand. Data - available internal or external data. Demonstration - who is doing it well (benchmarks, best practices)? Demand - Who or what is driving change (Regulations/requirements, leadership)?	Yes	
Action Plan	Action items identified throughout the change management process exercises and included in the overarching PIP work plan for accountability.	Yes	

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Plus, Delta	The groups feedback on what is positive or repeatable about the CMP process and what they would change about it.	Yes	
The following initial conclusions originated from the activities above:			
1	Internal and external bandwidth in normal times is stretched, COVID has exacerbated that. Work like this includes a lot of new processes, meaning time to develop materials, train, and implement new workflows. Staff and providers have a lot of initiatives to prioritze.		
2	The community cares about diabetes prevention and management. Evident by the many initiatives across clinics and community based organizations.		
3	Intervention efforts need to build on each other and ultimately support the behavior changes each individual needs to make to reduce their A1cs.		
4	A multidisciplinary care team approach will best help people diagnosed with diabetes: primary care provider, pharmacist, behavioral health provider, endocronoligist, dietrician, diabetes educator, and more.		
5	The community, in addition to CHA/CCC, is prioritizing SDOH work - screening clients and connecting them to resources. Everyone is in agreement that addressing SDOH needs is integral in chronic disease management and wellness in general.		
6	Findings from Root Cause Analysis:		
	Effect we want to influence: **Improve health for people with diabetes, HbA1c poor control**		
	Summary of information from Fishbone and 5 Whys exercises performed by the Diabetes PIP Team		
	Root cause(s):		
	Members forget to check their blood glucose levels throughout the day		
	Lack of diabetes education		
	Need wraparound help - care team approach - dietitian, endocrinologist, RN, classes		
	What data supports these root causes?		
	Pharmacists state that individuals forget to check or bring in monitors		
	Case managers unable to view current glucose levels		
	Very few education options locally		
	[redacted] data shows disconnect of care		

SHCN Diabetes Project

Cause and Effect Diagram

Diabetes PIP

Date: 8/14/2020