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Section 1: Transformation and quality projects

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

A. Project title: SPMI and THW Sustainable Capacity

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

If continued, insert unique project ID from OHA: 59

B. Components addressed

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

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

Continued projects

1. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** In 2023, the focused on Behavioral Health Integration and Serious and Persistent Mental Illness (SPMI), has seen substantial strides in enhancing the capacity of Transitional Health Workers (THWs). CHA and its community partners leveraged the Healthy Klamath Connect (HKC) platform to streamline access to over 200 programs from more than 150 local community-based organizations. This initiative significantly addressed the Social Determinants of Health (SDOH) and improved care coordination. The project also enhanced data collection efforts and targeted interventions for the Hispanic community in Klamath County, representing 14% of the population. Additionally, REALD & GI data integration has been prioritized to better track and address disparities within the project population.
2. **Describe whether last year's targets and benchmarks were met (if not, why):** The last year's targets, particularly those aimed at improving integration and utilization metrics for Behavioral Health, were met with varying degrees of success. The collaboration with the Hispanic Health Committee led to enhanced community-specific data collection and intervention refinements. However, there were challenges due to the small sample size in capturing comprehensive REALD & GI data, which restricted the depth of data analysis. Despite these challenges, the project made notable progress in enhancing THW capacity and integrating care services.
3. **Lessons learned over the last year:** Over the past year, several key lessons have been learned: The importance of culturally and racially oriented interventions is crucial, especially in a diverse community like Klamath County. Engaging with community-specific groups like the Hispanic Health Committee has proven essential in refining interventions to be more culturally relevant. Building strategic partnerships, such as those with Klamath Community College and local tribes, has facilitated more comprehensive community engagement and resource sharing. The necessity for continuous improvement in data collection and analysis to accurately measure and respond to health disparities has become evident. This includes expanding the capture and utilization of REALD & GI data. There is a

need for deeper collaboration with tribal representatives to enhance culturally competent care and to ensure sustainable health improvements across all community segments. These insights will guide CHA's ongoing efforts to refine and enhance the project's effectiveness, ensuring that it not only meets but exceeds its objectives in the coming years.

The Oregon Health Authority's (OHA's) Project #59 included key elements of Behavioral Health Integration and Serious and Persistent Mental Illness (SPMI). The project's primary focus was on enhancing the sustainable capacity of Transitional Health Workers (THWs). This initiative is set to continue into 2024.

In 2023, CHA and its community partners continued to leverage FindHelp, a Community Information Exchange (CIE) platform, branded locally as Healthy Klamath Connect (HKC). HKC serves as a comprehensive repository, listing available resources and local community service options for all residents, including CHA members, addressing Social Determinants of Health (SDOH) and care coordination needs.

HKC hosts over 150 local community-based organizations (CBOs) that offer more than 200 programs, providing services such as clothing, medical supplies, food, housing advice, temporary shelter, transit services, and legal and financial assistance. As a closed-loop referral system, HKC allows CBOs to claim their programs, enabling their staff to manage incoming and outgoing referrals through an intuitive user interface.

CHA staff have dedicated interfaces within HKC and Essette (CHA's case management platform) to manage CHA members' needs based on captured SDOH data. They use HKC to monitor closed-loop referrals, ensuring members receive the services they were referred to. Beyond referrals, HKC also functions as a social-needs platform, connecting members to essential resources like clothing and food.

In 2023, CHA increased its collaboration efforts with the Hispanic Health Committee (HHC), led by Klamath County Public Health (KCPH) to enhance data collection methods and refine interventions targeting the Hispanic community in Klamath County, which represents 14% of the population. CHA and The HHC recognized the potential of integrating existing initiatives like the local ACES and Resiliency training series, stigma reduction programs, and targeted presentations aimed at reducing mental health stigma. These initiatives are strategically aligned with the project's overarching goals of improving health outcomes and reducing disparities, emphasizing the need for culturally and racially oriented interventions that go beyond mere language accommodation to genuinely reflect the community's diverse demographic makeup.

Additionally, the appointment of CHA's CCO tribal liaison and Klamath Tribes tribal representative to the Community Advisory Council (CAC) marks significant progress in strengthening ties with the Klamath Tribes. Building on this foundation, CHA plans to implement targeted actions such as co-developing health programs and community engagement initiatives with tribal members. This collaborative strategy aims to enhance the cultural competency of health interventions and foster more sustainable health improvements throughout the community, ensuring that both the Hispanic and tribal populations receive culturally sensitive, impactful health services.

In June 2023, CHA collaborated with Klamath Community College (KCC) to secure a grant aimed at developing a local Community Health Worker (CHW) training program and providing training for 80 individuals through an "earn to learn" initiative. The Oregon Health Authority has since announced its intent to award KCC a Healthy Oregon Workforce Training Opportunity (HOWTO) grant of up to $270,000 over three years. This grant will support the creation of a non-credit CHW training and certification program designed to serve both Klamath and Lake counties. Additionally, the funding will facilitate the training of over 80 students within an "earn to learn" framework. KCC is partnering with Cascade Health Alliance to develop and

implement this program, ensuring a continuum of care through comprehensive training and certification of community health workers.

In 2023, the Healthy Rural Oregon HRSA grant fully funded 27 training opportunities for 21 individuals within our service area (see table below). This grant also subsidized registration costs for a local Peer Support Specialist - Adult Mental Health training, benefiting 22 participants in July 2023. Overall, the grant facilitated 49 training opportunities for 43 individuals throughout the year. These initiatives are pivotal in decreasing health disparities and improving health outcomes by enhancing the skills and capabilities of local health workers, thereby strengthening the support network for underserved populations.

Figure 1

Completed or In Progress Trainings	N
Peer Support Specialist for Adult Addictions - Certified Recovery Mentor	10
Community Health Worker	5
CADC1	2
Birth Doula	2
Mental Health First Aid Training Instructor Certification	2
Peer Support Specialist for Adult Mental Health	2
Diabetes Essentials for Paraprofessionals	2
Medical Assistant	1
Mental Health First Aid for Veterans	1
Total	**27**

These training programs are instrumental in decreasing health disparities and improving health outcomes by enhancing the capabilities of local health workers. By focusing on integrated care models that blend behavioral health with physical and oral health, these initiatives ensure a comprehensive continuum of care. This includes prevention, treatment, maintenance, and recovery, as well as effective care coordination and seamless transitions.

Furthermore, the use of electronic health records and health information exchange systems supports the delivery of integrated care. The structured care teams, encompassing all relevant disciplines, are critical for addressing the diverse needs of the community. Strong collaboration with regional health providers and community partners, such as school-based health centers, substance use disorder providers, community mental health programs, primary care providers, and law enforcement, further strengthens the support network for underserved populations, driving equitable health outcomes.

Another area where CHA supports integration is through efforts to improve the Initiation & Engagement in Treatment of Alcohol and Other Drug (IET) OHA incentive metric as part of CHA's Performance Improvement Project (PIP). CHA hosts a monthly collaborative discussion focused on the needs of substance use disorder (SUD) patients and expectations for their treatment and support. This collaboration includes representatives from both behavioral health (BH) and primary care facilities, aiming to reduce access barriers, expedite referral times, and enhance the overall effectiveness of SUD treatment.

CHA concentrates on areas where diagnoses occur outside of 42 CFR Part 2, such as emergency departments (ED) and other non-SUD specialty care settings. Utilizing Reliance data, CHA has developed a daily

notification process that provides real-time diagnosis information, enabling better access tools for Primary Care Practices (PCPs) to engage case management resources promptly. This improved communication, clear expectation setting, increased metric understanding among providers, and effective referral system are crucial for the coordination of care for this marginalized and stigmatized population.

From November 2022 through October 2023, CHA achieved significant improvements in member initiation and engagement in SUD treatment services. For members aged 13 and older, the initiation rate was 45% with an engagement rate of 22%. For those aged 13-17, the initiation rate was 38% with an engagement rate of 33%, and for members aged 18 and older, the initiation rate was 45% with an engagement rate of 22%. These efforts have led to increased utilization of treatment services, enhanced performance on the IET metric, and improved health outcomes for members who initiate and engage in SUD treatment.
These initiatives demonstrate CHA's commitment to integrating behavioral health with physical health, improving care coordination, and reducing health disparities, thereby contributing to a more equitable and effective healthcare system.

Furthering community involvement in behavioral health (BH) integration, Klamath Basin Behavioral Health (KBBH) and Sky Lakes Medical Center (SLMC) continue to operate The Link Access Center (LAC) in Klamath Falls. This collaborative BH and sobering center provides walk-in behavioral health services daily and offers voluntary sobering services 24/7. The LAC serves as a crucial entry point for individuals facing mental health and addiction challenges, aiming to eliminate barriers to accessing local BH services.
The collaborative efforts at the LAC include staffing and operational support from The Klamath Tribes, ensuring that services are culturally responsive and adhere to best practices for the Tribal community. This partnership exemplifies the integration of behavioral health with physical health services, enhancing care coordination and accessibility while addressing the unique needs of the Tribal population.

Klamath Health Partnership (KHP), operating as Klamath Open Door (KOD), a Federally Qualified Health Center (FQHC), remains a model of fully integrated care by offering physical, oral, and behavioral health services at a single location. For patients with more intensive behavioral health needs, KHP has a primary care provider co-located at Klamath Basin Behavioral Health (KBBH), a Community Mental Health Program (CMHP). This setup allows for the assessment of physical and oral health needs, with referrals to Klamath Open Door's main clinic for further treatment as necessary.

Additionally, when a primary care provider identifies a behavioral health need during a patient visit, they assist the patient in scheduling an appointment with a behavioral health professional before the patient leaves the clinic. This streamlined process ensures immediate and integrated care, demonstrating KHP's commitment to best practices in health integration. As integration efforts continue, KHP serves as a leading example of how to effectively combine physical, oral, and behavioral health services to improve patient outcomes and reduce health disparities.

All these integration efforts in the county are aimed at optimizing the use of behavioral health resources, which are often limited in a rural region. CHA continues to collaborate with local partners to provide additional training for traditional health workers (THWs) who serve the community. THWs play a critical role in identifying patients needing specific services and ensuring appropriate referrals. They also serve as an early intervention resource to address issues before they escalate in severity.

By promoting further training for THWs, CHA aims to ensure that each member's needs are matched with qualified resources. When combined with integrated referral systems like Healthy Klamath Connect (HKC) and active monitoring of patient segments, CHA's behavioral health staff are enhancing care by proactively utilizing

available services. These efforts underscore CHA's commitment to improving health outcomes and reducing disparities through effective and efficient behavioral health integration.

D. Brief narrative description

1. **Project population:** The project focuses on a diverse population that includes individuals with Serious and Persistent Mental Illness (SPMI) and members served by Traditional Health Workers (THWs) utilizing Peer Support Services. This population is characterized by various demographic segments based on race, ethnicity, and language preferences, as identified through the utilization data: Race: Caucasian (62%), Hispanic (5%), American Indian (3%), Other races and options (4%) Ethnicity: Other white (54%), Hispanic or Latino (4%), American Indian (3%), African/African American (3%) Language: Predominantly English (91%), with a smaller proportion of Spanish speakers (2%). The data indicates a need for tailored interventions that address the specific needs and disparities faced by these groups.
2. **Intervention (address each component attached):** The intervention comprises several key components aimed at improving care delivery and management: Data Monitoring and Reporting: CHA is expanding its capacity to monitor and report on service utilization, with a particular focus on capturing REALD and SOGI data to identify and address disparities. Monthly reports are generated to track utilization trends across primary care, specialty care, behavioral health, institutional care, pharmacy, and dental services. Case Management for SPMI: An enhanced case management approach targets members with high ED usage and an SPMI diagnosis, aiming to integrate these efforts into routine operations to provide consistent and effective care. THW Capacity Building: CHA is enhancing THW capacity within the delivery network through the evaluation of best practices, development of specific policies, and monitoring of THW service utilization. This includes the implementation of a tracking and reporting system to capture detailed data on THW utilization. Cultural and Language Considerations: Interventions are being tailored to the diverse needs of the community, particularly focusing on improving services for Hispanic and tribal populations through collaboration with community groups and advisory councils. Data Integration and Future Strategy CHA is developing strategies to collect and utilize SOGI data during member onboarding to better stratify behavioral health and other quality metrics. This data will enhance service delivery tailored to the diverse needs of members. Additionally, CHA plans to integrate dashboards for REALD and SOGI into SPMI and THW services in 2024. These dashboards will help identify disparities across member populations and facilitate targeted outreach to underserved communities, aligning with CHA's overarching goals of enhancing care coordination, reducing health disparities, and improving health outcomes.

While the utilization review and MEPP components have been removed this year, CHA maintains a robust utilization management program that encompasses authorization and review of medical, behavioral health, dental, and pharmacy services. This oversight is conducted by the Case Management and Pharmacy departments, under the supervision of the Chief Medical Officer, the Utilization Review Committee (URC), and the Pharmacy and Therapeutics (P&T) Committee.

Figure 2

SPMI with High ED Use - 2023 Cohort

Starting Cohort	102
Final Cohort	93

	Final Cohort Values at Start of Intervention (April 2023)		Final Cohort Values at End of Intervention (October 2023)		Difference	% change
Potentially Avoidable Costs	$300,200	16.61%	$363,200	19.38%	-2.77%	-16.69%
Total Costs	$1,807,700		$1,874,300			
ED Visits Prior 12 Months	1030		884		146	14.17%
ED Visits Prior 6 Months	639		359		280	43.82%

Schizophrenia with High ED Use - 2023 Sub-Cohort

Starting Cohort	26
Final Cohort	23

	Final Cohort Values at Start of Intervention (April 2023)		Final Cohort Values at End of Intervention (October 2023)		Difference	% change
Potentially Avoidable Costs	$86,100	15.33%	$70,700	13.58%	1.75%	11.44%
Total Costs	$561,600		$520,700			
ED Visits Prior 12 Months	284		195		89	31.34%
ED Visits Prior 6 Months	169		57		112	66.27%

CHA is expanding its capacity and workflows to gather and monitor utilization data through monthly generated reports. These reports encompass primary care, specialty care, behavioral health, institutional, pharmacy, and dental claims, with a focus on evaluating trends based on REALD (Race, Ethnicity, Ability, Language, and Sexuality) and SOGI (Sexual Orientation and Gender Identity) information where available. This approach helps identify and address disparities in utilization effectively.

Additionally, CHA conducts individualized reviews of high-utilization cases to optimize care management. Despite existing policies and procedures, CHA continues to refine workflows and enhance capacity to produce comprehensive utilization reports regularly. This effort aims to pinpoint opportunities for improvement across all service types.

For 2023, Peer Support Services utilization based on race includes:

- Caucasian: 62%
- Declined to Answer or Did not Answer: 19%
- Blank: 7%
- Hispanic: 5%
- American Indian: 3%
- Other races and options: 4%

Peer Support Services utilization based on ethnicity:

- Other white: 54%
- Blank: 10%
- Unknown: 10%
- Declined to Answer: 8%
- Western European: 3%
- Hispanic or Latino: 4%

- American Indian: 3%
- African/African American or other African: 3%
- Other categories and options: 5%

Peer Support Services utilization by language:

- English: 91%
- Blank: 7%
- Spanish: 2%

Figure 3

2023 Peer Support Services

Year & Quarter	Unique Members Served	Total Volume of Services
2023		
Qtr1	971	7311
Qtr2	996	7168
Qtr3	971	7221
Qtr4	1059	7797
Grand Total	3997	29497

CHA will continue to execute its THW Integration and Utilization Plan to enhance THW capacity within the delivery network. This includes evaluating best practices, developing internal policies and procedures specific to THW care coordination, and monitoring THW service utilization. CHA will also establish measurable outcomes to effectively capture and assess the impact of THW services, which are currently not fully captured through encounter claim data. As reporting requirements evolve to include more detailed and stratified THW utilization data in the Klamath community, CHA plans to implement an active tracking and reporting system. This system will enable precise data collection on key metrics such as the number of providers utilizing THWs, the active count of independent THWs in the community, and the unduplicated count of members receiving THW services.

In 2023, CHA updated its Serious and Persistent Mental Illness (SPMI) cohort for enhanced case management, focusing on members with high Emergency Department (ED) utilization and an SPMI diagnosis. Building on the success of this initiative, CHA aims to establish a consistent approach and integrate this work into routine operations.

Looking ahead, CHA is developing a strategy to collect Sexual Orientation and Gender Identity (SOGI) data during member onboarding. This data will be used to stratify behavioral health and other quality metrics, enhancing service delivery tailored to diverse member needs.

The SPMI and THW Sustainable Capacity project (OHA Project #59) will support CHA's utilization management program through the utilization of Optumas, MedInsight, and other data sources. Key metrics to be tracked include members declining intervention versus those accepting, ED utilization comparisons between intervention and non-intervention cohorts, and the number of members referred to THWs.

Moving forward into 2024, CHA aims to integrate dashboards for REALD and SOGI into SPMI and THW services. These dashboards will enable the identification of disparities across member populations and facilitate targeted outreach to underserved communities.

In conclusion, CHA's ongoing efforts in integration and utilization management are crucial for enhancing care coordination, reducing health disparities, and improving health outcomes in the Klamath community. By implementing robust data-driven strategies and fostering collaboration across various healthcare disciplines and community partners, CHA is poised to achieve significant advancements in integrated care delivery for the year ahead.

Supporting Documents:

Health Promotion and Prevention Policy and Procedure

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

Activity 1 description: Increase community capacity of THW/CHW/Peer Recovery Mentors/Support Specialists through curriculum development, program execution; create mechanism for sustainability of education and certification program.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Monitor the number of newly trained THWs (Community Health Workers/Peer Wellness Specialists/Peer Support Specialists/Doulas/Patient Health Navigators).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2023 27 THW trainings were completed	THW training for at least 20 more individuals are scheduled	07/2024	THW training for at least 20 individuals is completed	12/2024

Activity 2 description: Utilize predictive analytic platforms/tools to identify the target cohort, assign intervention to cohort members, and develop targeted, individualized integrated care plans.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Continue to identify SPMI cohort members; establish targeted and individualized care plans for cohort members.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
New 2024 SPMI cohort is based on active members with SPMI diagnosis	Active care plans for 25% of cohort members are established	09/2024	Active care plans for at least 50% of cohort members are established	12/2024

A. Project title: Cultural and Linguistic Services Provision

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

If continued, insert unique project ID from OHA: 33

B. Components addressed

1. Component 1: CLAS standards
2. Component 2 (if applicable): Health equity: Cultural responsiveness
3. Component 3 (if applicable): Choose an item.
4. Does this include aspects of health information technology? ☒ Yes ☐ No
5. If this is a NCQA HE Standards project, 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

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

Continued projects

4. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** Cascade Health Alliance (CHA) made significant progress towards its health equity goals in 2023, positioning itself well for 2024. Throughout the year, CHA enhanced its reporting capabilities for member demographics, including interpreter needs, and race, ethnicity, language, and disability (REALD) data. This expansion helps to identify the cultural and linguistic needs of members through a comprehensive demographics dashboard that includes REALD, age, gender, and marital status.
5. **Describe whether last year's targets and benchmarks were met (if not, why):** While CHA made commendable progress in many areas, certain targets were not fully met due to several challenges. High service demands and labor market constraints impacted initiative timelines and restricted collaboration opportunities, affecting the completion rate of Language Line training for certified interpreters. Only 21 out of 54 participants completed their training, falling short of the 75% completion target, primarily due to employment changes, lack of time, and de-prioritization of training amidst other responsibilities.
6. **Lessons learned over the last year:** The past year underscored the importance of adaptability and the need to continually refine strategies to meet community needs effectively. One key lesson was the critical need to enhance staffing strategies to counter the effects of high turnover and labor shortages, particularly in securing bilingual staff and trained interpreters, which are essential for providing culturally and linguistically appropriate services. Additionally, the expansion of data collection and utilization highlighted the necessity for robust infrastructure to manage and analyze health equity data effectively, leading to better-targeted health interventions and improvements in member engagement and service delivery. These insights are guiding CHA's ongoing efforts to improve health equity, including refining recruitment processes, enhancing training programs for cultural competence, and leveraging technology to better meet the diverse needs of the community.

In 2023, Cascade Health Alliance (CHA) and Klamath County faced challenges like those experienced by many communities. High service demand and a challenging labor market led to bandwidth constraints, impacting initiative timelines, and limiting opportunities for collaboration with community partners. Both CHA and local organizations struggled to fill roles critical to quality, equity, and service delivery.

In 2023, CHA started seeking a vendor to develop a more advanced dashboard, as CHA lacked the specialized tools to create it internally. The Population Health (PH) Dashboard, formerly known as the Health Equity (HE) Dashboard, will ultimately provide a holistic view by aggregating multiple data sources with various filters.

This tool identifies trends and gaps to guide strategic initiatives. The PH Dashboard will utilize quality reports stratified by REALD and SOGI (Sexual Orientation and Gender Identity), covering aspects such as disease prevalence, health outcomes, provider assignments, access, utilization, incentive metrics, FBDE (Full Benefit Dual Eligible), LTSS (Long-Term Services and Supports), SDOH (Social Determinants of Health), G&A (General and Administrative), improvement project outcomes, and other member demographics.

The insights gained from the PH Dashboard will guide CHA in strategic planning and developing interventions to eliminate health disparities. This will be achieved by creating targeted and tailored member outreach, communication, education, and quality improvement opportunities. Once completed, the equity dashboard information will be integrated into CHA's Case Management Platform, providing member-facing staff with comprehensive access to member-level data. Currently, limited equity data is available in the platform, but utilization will focus on targeted outreach, communication, education, and quality improvement.

In 2023, with 5.7% of CHA members being Spanish-speaking, CHA focused on ensuring all member materials were available in Spanish. Historically, most materials were already translated into Spanish. CHA's website features a button on the homepage that allows users to translate the entire site, including the Provider Directory, into Spanish. Providers who speak languages other than English are noted in the Provider Directory.

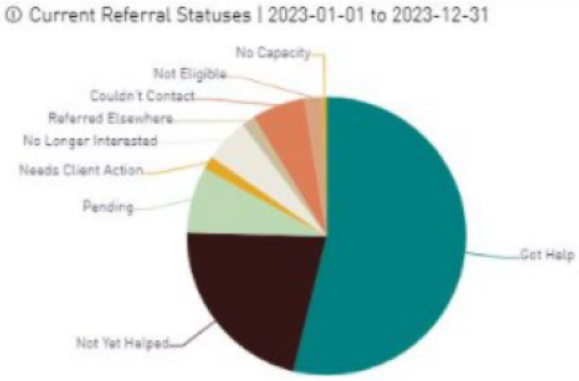
For educational campaigns, CHA sends text messages in Spanish to members whose preferred language is Spanish. Additionally, the member handbook is available in both audio and large print formats. All other materials can be quickly produced in large print upon request. While most member materials are not immediately available in audio format, they are provided within 48 hours of a request.

Additionally, CHA collaborates with its provider network to ensure the delivery of culturally and linguistically appropriate services to members. This includes identifying areas of opportunity, addressing service gaps and community resource deficiencies, and resolving consistent member complaints. CHA's annual provider audits verify that clinics have policies and procedures for using language lines, offer ADA accessibility, and provide access to emergent, urgent, and after-hours care. When issues arise or gaps are identified, CHA develops corrective action plans with defined strategies, target dates, deliverables, and additional monitoring programs to address and improve deficient services.

CHA is one of the 'Core Four' agencies that lead the Healthy Klamath partnership, a coalition (Healthy Klamath Network) comprised of over 150 local Community Benefit Organizations (CBOs), health providers, and Klamath County Public Health. This coalition collaborates extensively to improve community health. In 2023, CHA and its community partners continued to utilize the Community Information Exchange (CIE) platform known as Healthy Klamath Connect (HKC). HKC serves as a central repository for listing and accessing resources, providing local community services options for all members, including those addressing Social Determinants of Health (SDOH) needs.

The online platform features over 150 local community-based organizations offering more than 200 programs, ranging from clothing, medical supplies, and food to care coordination, housing advice, temporary shelter, transit services, and legal aid. CHA staff have a specific user interface to assist with managing CHA members based on captured SDOH in HKC and Essette (CHA's Case Management platform). Additionally, HKC functions as a social-needs referral platform to connect members to SDOH resources. (Figure 4)

Figure 4



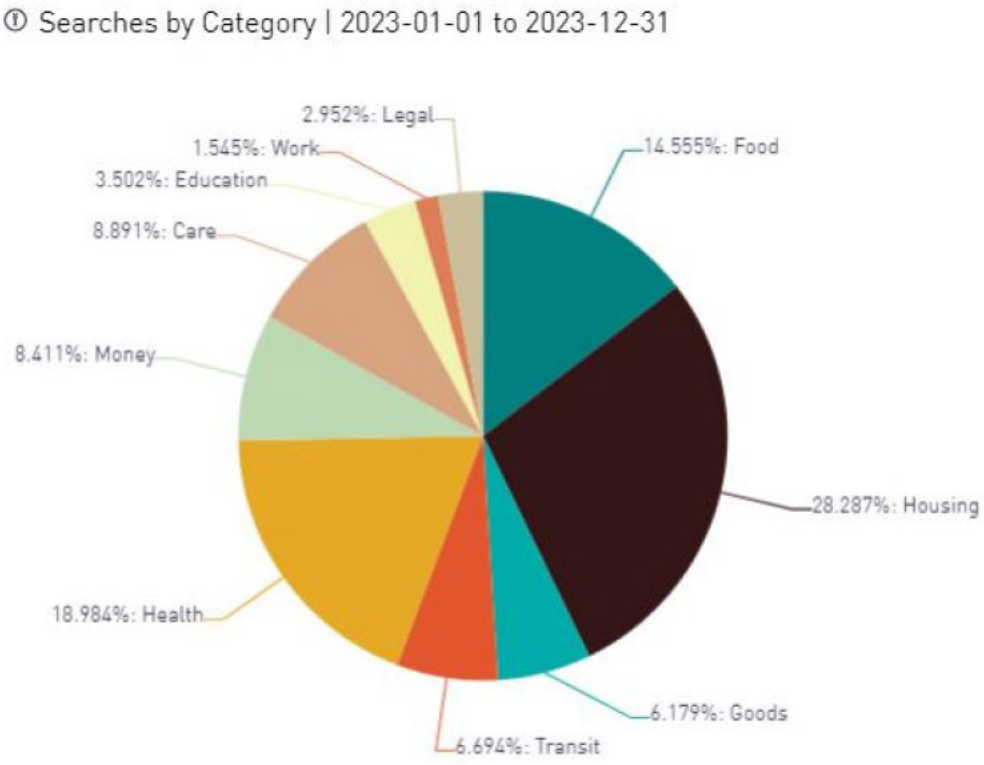
Most Referred to Programs | 2023-01-01 to 2023-12-31

ORGANIZATION	ORGANIZATION URL	PROGRAM	PROGRAM URL
Sky Lakes Medical Center	https://hkc.auntbertha.com/provider/view/4654202221232128	Outpatient Care Management	https://hkc.auntb
Klamath & Lake Community Action Services (KLCAS)	https://hkc.auntbertha.com/provider/view/5464178469634048	Homeless Prevention Progr...	https://hkc.auntb
Klamath Health Partnership	https://hkc.auntbertha.com/provider/view/5023086810365952	Klamath Open Door Care C...	https://hkc.auntb
Cascade Health Alliance (CHA)	https://hkc.auntbertha.com/provider/view/4779435901059072	Flexible Services (FS)	https://hkc.auntb
Klamath Health Partnership - Chiloquin Open Door Family Practice	https://hkc.auntbertha.com/provider/view/5469142415310848	Medical Services	https://hkc.auntb
CHA CBO Training	https://hkc.auntbertha.com/provider/view/6046391588225024	Demo Housing Program - C...	https://hkc.auntb
Klamath & Lake Community Action Services (KLCAS)	https://hkc.auntbertha.com/provider/view/5464178469634048	Energy Assistance Program	https://hkc.auntb
The Salvation Army Service Center Klamath Falls	https://hkc.auntbertha.com/provider/view/4935908851318784	Emergency Financial Assist...	https://hkc.auntb
United Community Action Network (UCAN)	https://hkc.auntbertha.com/provider/view/5884195580674048	Healthy Families Program	https://hkc.auntb
Cascade Health Alliance (CHA)	https://hkc.auntbertha.com/provider/view/4779435901059072	Maternity Program	https://hkc.auntb

CHA also continued its participation in the local Southern Oregon Health Information Exchange (HIE), Reliance eHealth Collaborative. Reliance eHealth includes some SDOH reporting, such as housing and food insecurities. CHA shares 837 data files with Reliance, and other healthcare organizations contribute SDOH data from their electronic health records (EHRs)

To further identify and address social needs gaps, CHA has established a multidisciplinary team dedicated to enhancing Social Determinants of Health (SDOH) screening and referrals through Healthy Klamath Connect (HKC). This initiative aims to improve the identification of social needs and reduce health disparities for all members, including those who may not have previously received culturally and linguistically responsive services. (Figure 5)

Figure 5



This effort is tracked through the SDOH Screening and Referral Process performance improvement project (PIP), which is currently focused on building infrastructure for SDOH screening and referrals. Through the PIP, CHA is evaluating, testing, and updating current processes for social needs screening, data capture, data sharing, and closed-loop referrals. CHA also leverages SDOH data from various sources to identify both member-level and community-level needs. These data sources include Health Risk Assessments (HRAs), the Klamath County Community Health Assessment, and Well-Being data from the BlueZones RealAge Test.

In 2023, CHA expanded its collection and utilization of Social Determinants of Health (SDOH) demographic data to better recognize and address member needs. Reporting capabilities were enhanced through Health Risk Assessments (HRAs), SDOH screenings, and new protocols for obtaining member need information. Members receiving services from the Health Equity department were screened using the PRAPARE screener, which records REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) demographics. The PRAPARE screener has been established as a standardized tool for all SDOH requests.

CHA improved its data collection and utilization processes and updated policies and procedures to better meet the needs of members with disabilities. An environmental scan was conducted to better understand local resources available to support people with disabilities.

CHA is continuously enhancing the information gathered from members to create a more complete picture of member demographics. The new HRA screening questions aim to provide a more functional description of member abilities, making it easier to assess and complete referrals for functional needs. The new HRA is currently in the approval phase and will be implemented once approved.

The Community Information Exchange system (Healthy Klamath Connect or HKC) currently identifies 128 programs that serve individuals with disabilities. These state, national, and local resources can easily accept referrals from CHA members when staff members are addressing member needs.

CHA has worked diligently to identify organizations that serve specialized populations. Through community partnership events, networking, and projects to improve the upkeep rate of programs on HKC, CHA has become more in touch with available organizations. Klamath County Developmental Disability Services was identified as a key partner for member outreach. Other organizations, such as SPOKES, the Oregon Department of Education, and CaCoon, have claimed their programs on HKC to assist individuals with disabilities. When a member with a disability seeks specialized help, CHA can refer them to a variety of organizations with specific subspecialties.

CHA established a new Health Risk Assessment (HRA) to gather a broader range of demographic information. This HRA will be conducted for every member receiving case management services and includes REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) demographic information, such as:

- Race
- Spoken and written language
- Gender identity
- Sexual orientation
- Preferred pronouns

Additionally, the HRA includes questions regarding health functionality and disability to assess the current needs and risks of the member's health and social situations. Once approved and implemented, this SDOH demographic data will be captured and aggregated to identify previously unrecognized demographic disparities."

During 2023, CHA collaborated with organizations such as Citizens for Safe Schools (Pride Circle Program), Klamath Advocacy Center, and HIV Alliance to serve individuals who identify as transgender, nonbinary, or gender diverse. These organizations have claimed their programs on Healthy Klamath Connect.

Due to resource constraints in 2023, CHA was unable to review and reassess all existing policies and procedures to incorporate the needs of transgender, nonbinary, or gender diverse populations. However, moving forward, we will include REALD-SOGI demographic reviews in all policies and procedures as they come up for annual review, as well as ensure these considerations are included in all newly created policies.

The Demographic Review policy was created to identify inequities within the scope of financial, performance, and population health reports. Approved in December 2023, this policy ensures the identification of important demographic data. REALD and SOGI data are incorporated into this policy framework to better understand how these demographic factors affect member experience outcomes.

Cascade Health Alliance (CHA) takes a leading role in multiple community engagement activities that align with NCQA HE Standards and the Health Equity Plan (HEP). During these gatherings, CHA shares insights on community outreach, prioritization of equity work, and potential partnership opportunities. Additionally, CHA frequently updates on the administration of Social Needs benefits, focusing on programs that facilitate equitable access to services and reduce barriers, thereby enhancing community health engagement and collaboration across Klamath County. Some of these initiatives are outlined below:

Community Advisory Council (CAC): The Community Advisory Council (CAC) at Cascade Health Alliance (CHA) holds monthly meetings facilitated by the CAC Coordinator. These sessions focus on providing updates from the Oregon Health Authority (OHA), reviewing progress on the Health Equity Plan (HEP), and enhancing collaboration with key community partners. The CAC Coordinator plays a crucial role in bridging communication between the CAC and CHA's leadership team. This ensures that the voices and perspectives of members are effectively communicated and considered in organizational decision-making and strategy development.

Healthy Klamath Network: The Healthy Klamath Network is a robust coalition comprising over 50 local organizations from diverse sectors such as media, government, education, economy, family, religion, arts, and entertainment. This network plays a pivotal role in guiding community health efforts throughout Klamath County. CHA actively participates in the quarterly Healthy Klamath Network meetings, providing updates on the Community Health Improvement Plan (CHIP) Equity components. These meetings offer a platform for other organizations to contribute input on CHIP equity initiatives, allowing for necessary reprioritization and strategizing.

CHA/CHIP Leadership: CHA contributes to a shared Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) developed every three years in collaboration with Klamath County Public Health, Klamath Health Partnership, and Sky Lakes Medical Center. Monthly CHA/CHIP Leadership meetings provide updates on HEP progress and facilitate community listening sessions.

CHIP Workgroups: Multiple workgroups focus on 2023 CHIP priorities such as food insecurity, health promotion, mental health, physical activity, substance use, and equity, with CHA representatives actively participating.

Hispanic Health Committee: A subcommittee of the Healthy Klamath Coalition, the Hispanic Health Committee aims to enhance health and wellbeing among Klamath County's Hispanic population. In 2023, the committee launched 'La Voz de Klamath / The Voice of Klamath,' a Spanish-language streaming radio station to promote community events, health fairs, and educational activities.

Klamath Promise: This collaborative spans P20 education levels (Pre-K through graduate school), fostering skills and readiness for college, careers, and civic engagement. CHA provides updates on health equity efforts and relevant partnership opportunities. Klamath Promise is a key partner in the region's Systems of Care (SoC) that is coordinated and led by CHA.

Community Housing Plan Meeting: A forum for diverse community partners—including Klamath and Lake Community Action Services, Klamath Housing Authority, Klamath Tribes, and others—to plan, collaborate, and secure resources for safe, affordable housing in Klamath County. CHA actively participates in this monthly meeting to provide updates on housing needs for our members and to educate community partners working with members on Flexible Services and the Health Related Social Needs (HRSN) housing benefits

Faith-Based Core Group: Local faith leaders collaborate to support community initiatives, with CHA and other network members providing support as needed.

Klamath and Lake County Community Partner Outreach Program: Facilitated by OHA, this collaborative includes CHA and EOCCO (Lake County CCO), providing updates on care coordination and social determinants of health efforts to community-based organizations.

Systems of Care (SOC) Committee: CHA leads the local SOC which supports and coordinates a network of services and supports that are organized to meet the needs of children and families. SOC aims to improve the access, quality, and effectiveness of services for children with mental health challenges and their families by promoting collaboration among various service providers, including healthcare, education, social services, and community-based organizations (CBO's). SOC is grounded in principles that emphasize family-driven and youth-guided care, cultural and linguistic competence, and a strengths-based approach. By integrating services across different sectors, SOC seeks to provide comprehensive, individualized care that supports the overall well-being and resilience of children and families.

Klamath and Lake Counties Area on Aging (KLCCOA) Advisory Council: CHA participates in the advisory council, aligning health equity efforts with KLCCOA's Equity Plan to support older adults in the community.

LGBTQIA2S+ Activities: CHA supports local programs such as Klamath PRIDE and Citizens for Safe Schools that support LGBTQIA2S+ youth and plans to gather SOGI data to better understand and support the LGBTQ+ population in the future.

Community Health and Resource Fairs: Cascade Health Alliance (CHA) engages in health fairs, outreach events, and community vaccine clinics throughout the Klamath service area. These events cater to both English and Spanish speakers, providing vital educational materials and resources to community members, enhancing access to health information and services.

Throughout 2023 and continuing into 2024, Cascade Health Alliance (CHA) has hosted monthly Community Fun Day events, offering the public access to free resources, information, games, and food in collaboration with community partners. These events aim to empower individuals to seek support for their health and well-being. Held at various locations across Klamath County, these events ensure accessibility for all county residents. These recurring community outreach events in rural areas of Klamath County, have served up to 250 individuals respectively.

A weekly rotating series of outreach events in Malin, Merrill, Sprague River, Chiloquin, Keno, and the Klamath County Courthouse, the Healthy Klamath Resource Market, launched in 2023, was created to bridge the gap between small, rural communities surrounding Klamath Falls and the essential resources provided by local community-based organizations (CBOs). Led by CHA in partnership with several community partners, this initiative ensures that residents in these underserved areas can easily access the support and services they need. By leveraging the online platform healthyklamathconnect.com, the Resource Market promotes a seamless and efficient way for individuals to search for and connect with a wide array of services, ranging from healthcare and social services to educational and recreational opportunities. This effort not only enhances the well-being of the rural population but also strengthens the overall community by fostering greater connectivity and support. Additionally, the Resource Market upholds cultural responsiveness and adheres to NCQA HE Standards by actively partnering with the community to design, implement, and evaluate policies, practices, and services that ensure cultural and linguistic appropriateness, thereby addressing the diverse needs of all residents.

In addition, CHA provides financial support to the community through the SHARE Initiative and Health Related Services (HRS). These funds support Community Benefit Initiatives aligned with the County Wide Community Health Improvement Plan (CHIP) and the 4 domains of Social Determinants of Health (SDoH). HRS Flex Funds specifically assist CHA members facing challenges in achieving optimal health outcomes.

During 2023, Cascade Health Alliance (CHA) made significant strides in advancing health equity and adhering to NCQA HE Standards. Notably, CHA focused intensively on CLAS Standard 13: partnering with the community to design, implement, and evaluate policies, practices, and services for cultural and linguistic appropriateness. Some initiatives directly aligned with Transformation Quality Strategy (TQS) activities, while others exceeded initial plans in innovation and transformation.

As part of the Cultural and Linguistic Services Provision (CLSP) project, CHA enhanced access and reporting related to interpretation needs through its partnership with Linguava, the language line vendor. Discussions on NCQA HE Standards were frequent within CHA's Health Equity led meetings, where various subcommittees explored strategies to enhance implementation across all fifteen NCQA HE Standards.

CHA has initiated steps towards acquiring NCQA Health Equity Accreditation to enhance its organizational capacity in delivering equitable services to members and improving equity literacy among employees. The first phase involves a gap analysis led by the Health Equity Director to assess CHA's current practices against NCQA standards.

Although the Equity Audit for 2023 was postponed due to staff turnover, it is currently underway for 2024. The audit focuses on conducting a gap analysis comparing CHA's policies and procedures with NCQA Health Equity Accreditation Standards. Upon completion, CHA will develop an equity workplan based on the identified standards from the gap analysis.

Cascade Health Alliance (CHA) remains committed to enhancing language access services in its service area, collaborating closely with Language Line to certify staff, partners, and providers as interpreters. In 2023, CHA extended its training contract to 54 applicants, including CHA employees, staff from provider offices, and community-based organizations. Despite progress in certifying interpreters, there persists a community need for in-person medical interpretation within CHA's service area.

Many individuals trained through Language Line also manage other job responsibilities, leading to challenges in dedicating sufficient time solely to interpretation. Consequently, several clinics operate without certified interpreters due to staffing constraints or time limitations. CHA continues to offer training opportunities to its staff and partners to improve language access for all members.

Staff turnover has significantly reduced the number of bilingual employees within CHA. To address this, CHA prioritizes hiring and training bilingual staff but faces challenges due to a limited pool of bilingual candidates in the service area. In instances where local certified translators are unavailable, CHA utilizes Linguava for ad-hoc translations. This partnership with Linguava and certified translators helps CHA better understand and meet the diverse language needs of its members.

While training opportunities are consistently offered, there remains a notable shortage of staff available for training, both within CHA and among its community partners. Despite successful training outcomes thus far, increasing bilingual staffing levels is crucial to fully meeting the demand for language access. CHA continues its collaboration with Language Line to disseminate training opportunities within the community and receives regular reports on trained individuals.

Of the 54 individuals enrolled in Language Line training to become certified interpreters, 21 successfully completed the program, falling short of the 75% completion metric set for 2023. Reasons cited for non-completion include changes in employment, time constraints, and competing priorities for training.

In 2023, Cascade Health Alliance (CHA) continued its collaborative efforts with providers to enhance encounter-level reporting on the use of certified/qualified interpreters. This initiative achieved over 80% data

collection from the provider network, marking significant progress. CHA also began receiving aggregated data from providers regarding variances in wait times and interpreter/translation costs. CHA staff actively engages with providers to promote Meaningful Language Access requirements and improvements, ensuring widespread adoption to analyze member accessibility and satisfaction during encounters.

CHA further solidified partnerships with community organizations employing culturally and linguistically appropriate methods to deliver services, enhancing awareness of available programs. Notably, Klamath County Public Health introduced a new linguistic program utilizing devices for real-time language translation during live events, which CHA leverages as needed to communicate effectively with non-English speaking members and audiences.

To bolster cultural competence, CHA expanded its Health Equity department with key hires, including the Health Equity Outreach Coordinator and two Social Determinants of Health (SDOH) Coordinators. These roles are integral in delivering culturally responsive services tailored to members' diverse backgrounds and circumstances. New Health Equity team members undergo certification as Traditional Health Workers within six months of hire, establishing trusted connections within the community through shared lived experiences. Training focuses on cultural competency, trauma-informed care, and addressing implicit bias, ensuring that services are sensitively attuned to community needs.

All Health Equity staff are equipped to effectively communicate community needs to partners and advocate for responsive care strategies that promote inclusivity and cultural responsiveness.

D. Brief narrative description

1. **Project population:** The project population for Cascade Health Alliance's (CHA) multi-year initiative encompasses members and the broader community within Klamath County. This population includes diverse demographic groups distinguished by various race, ethnicity, language, disability (REALD), and sexual orientation and gender identity (SOGI) profiles. The project aims to cater to the unique needs of these members by providing culturally and linguistically appropriate care and services, thereby ensuring that all members, particularly marginalized and vulnerable populations, have equitable access to healthcare services.
2. **Intervention (address each component attached):** **Enhanced Data Capture and Reporting:** The project includes significant improvements in data collection and reporting processes, incorporating REALD and SOGI data. This effort facilitates the stratification of quality reports and enriches member profiles in Essette, CHA's case management platform. These enhancements aim to identify and address the specific cultural and linguistic needs of the community. **NCQA Health Equity Accreditation:** A core component of the intervention involves pursuing the National Committee for Quality Assurance (NCQA) Health Equity Accreditation. The process includes a readiness review, gap analysis, and the creation of an implementation plan based on NCQA guidelines. This accreditation underscores CHA's commitment to meeting high standards in providing equitable healthcare. **Community Engagement:** Integral to the project is the involvement of the Community Advisory Council (CAC), which participates in the readiness reviews and gap analyses. This engagement ensures that community voices are incorporated into the planning and implementation phases, enhancing the relevance and effectiveness of health interventions. **Meaningful Language Access (MLA) Initiative:** This initiative enhances CHA's capacity to offer culturally and linguistically appropriate services. It involves enhanced reporting on members' language needs and the implementation of encounter-level interpreter-use reporting through provider EHR systems. The initiative aims to improve language service access and reduce wait times, thereby enhancing communication and understanding between healthcare providers and members. **Workforce Development:** The project emphasizes the importance of fostering organizational cultural competence. This is achieved through the introduction of new Health Equity staff

positions and ongoing training to help CHA personnel recognize implicit biases and enhance their cultural responsiveness. This component aims to build a workforce that is sensitive to and capable of addressing the diverse needs of the community. **Health Equity Committee:** The Health Equity (HE) Committee plays a critical role in aligning the organization's equity goals with NCQA HE Standards. It is responsible for guiding policy creation and ensuring that actions are informed by certified Traditional Health Workers (THWs) who bring valuable expertise in equity, inclusion, and bias identification. **Health Equity Audit:** An ongoing component of the intervention is the Health Equity audit, starting with a gap analysis under NCQA HE Standards. This analysis will inform subsequent policy, procedure, and action developments, guiding the organization toward more effective equity-focused healthcare delivery. These standards form the foundation of CHA's strategy to enhance health equity, address social determinants of health, and improve health outcomes across the community. The ultimate goal is to eliminate healthcare disparities and ensure that all community members receive high-quality, culturally competent care.

This multi-year project aims to achieve several NCQA HE Standards through internal initiatives and collaborations with our providers and community partners. As we enhance our infrastructure, Cascade Health Alliance (CHA) remains committed to ensuring that members can actively participate in selecting services delivered in settings that meet their unique needs.

Activities under the Cultural and Linguistic Services Provision (CLSP) project complement focus areas outlined in CHA's Health Equity Plan (HEP) and align with other Transformation Quality Strategy (TQS) projects. These efforts include enhancing data capture and reporting—incorporating race, ethnicity, language, disability (REALD) data, and sexual orientation and gender identity (SOGI) data—stratifying quality reports by REALD and SOGI, and enriching member profiles in Essette, CHA's case management platform.

The initial phase focuses on achieving National Committee for Quality Assurance (NCQA) Health Equity Accreditation. This involves conducting a readiness review, gap analysis, and creating an implementation plan using NCQA guidelines as the gold standard, while also adhering to Oregon state and federal accessibility and communication laws. Community engagement is integral, with the Community Advisory Council (CAC) participating in readiness reviews and gap analyses as outlined in the Health Equity Plan.

The NCQA HE Standards component of the TQS project emphasizes collaboration with our providers and community partners, mirroring internal efforts outlined in the Health Equity Plan. Throughout the NCQA Health Equity Accreditation process, all fifteen NCQA HE Standards will undergo rigorous review and integration into gap analyses and implementation plans. This comprehensive approach aims to ensure that CHA members and the Klamath community receive culturally and linguistically appropriate care and services, address social determinants of health, promote health equity, and mitigate healthcare disparities.

Upon completion of these improvements, CHA will seek NCQA Health Equity Accreditation, demonstrating successful alignment with all NCQA HE Standards and affirming our commitment to delivering high-quality, equitable care and services.

NCQA Health Equity Accreditation requires an organization to align with six standards:

- HE 1: Organizational Readiness (includes building a diverse staff and promoting diversity, equity, and inclusion among staff)
- He 2: Race/Ethnicity, Language, Gender Identify, and Sexual Orientation Data
- HE 3: Access and Availability of Language Services
- HE 4: Practitioner Network Cultural Responsiveness
- HE 5 Culturally and Linguistically Appropriate Services Programs

- HE 6: Reduction of Health Care Disparities

The NCQA Health Equity Accreditation will underscore CHA's commitment to transformation by establishing leadership in NCQA HE Standards within our community. This accreditation process engages our provider network and community partners to ensure equitable access to culturally and linguistically appropriate care and services for all members and the broader community. By achieving NCQA HE Standards across CHA's service area and Klamath County, and successfully obtaining NCQA Health Equity Accreditation, we aim to eliminate healthcare disparities, enhance care access for marginalized and vulnerable populations, improve member satisfaction, elevate service quality, advance health equity, address social determinants of health, and enhance health outcomes for all community members.

The Meaningful Language Access (MLA) initiative enhances CHA's ability to provide culturally and linguistically appropriate services to members through two key components: (1) enhanced reporting on members' language interpretation needs, access to qualified interpreter services, and utilization of language lines with additional detailed metrics; and (2) implementation of encounter-level interpreter-use reporting through provider electronic health record (EHR) systems, alongside improvements in data collection on wait times. Internally, CHA has begun reporting on language access needs and is collaborating with providers to ensure an equitable environment for all members. In 2024, this reporting will be further refined with detailed insights into access, availability, and wait times, enabling CHA to gather and analyze comprehensive data on language needs and identify any disparities impacting utilization.

The Workforce Development initiative continues to foster organizational cultural competence through new Health Equity staff positions, ensuring all CHA personnel receive training to recognize implicit biases and enhance cultural responsiveness. Ongoing training efforts aim to elevate staff cultural competence, mitigate implicit biases, and enhance cultural responsiveness, thereby promoting health equity across the organization.

CHA remains committed to integrating new health equity, inclusion, and diversity components into its strategic framework. The Health Equity (HE) Committee plays a pivotal role in aligning equity goals with NCQA HE Standards, guiding policy creation, and ensuring actionable guidance is informed by certified Traditional Health Workers (THWs) with expertise in equity, inclusion, and bias identification.

Continued progress in the Health Equity audit involves initial steps like gap analysis under NCQA HE Standards. This analysis will inform subsequent actions related to equity policies, procedures, and initiatives, guiding the framework for future steps in the Health Equity audit.

Supporting Documents

Demographic Review policy and procedure
Cultural responsiveness and implicit bias education and training plan policy & procedure
Cultural competency policy and procedure
Provider Network Management Committee Charter
2023 Member Demographics Dashboard
Healthy Klamath Connect (HKC) Flyer

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

Activity 1 description: Achieve National Committee for Quality Assurance (NCQA) Health Equity Accreditation, previously known as Distinction in Multicultural Health Care (MHC), for CHA through readiness review, gap analysis, implementation plan, and final application.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Partners identified, readiness review and gap analysis complete, and implementation plan(s) created			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2 PCPCH clinics at tier 5 (5 Star clinics have already implemented processes to achieve NCQA HE Standards)	1-2 provider partners identified	12/2024	Partner readiness review and gap analysis completed	06/2025
Monitoring measure 1.2	Readiness review and gap analysis for NCQA Health Equity Accreditation shared with CAC and HEC			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No readiness review conducted	Readiness review completed and shared with CAC and HEC	12/2024	Gap analysis produced and shared with CAC and HEC	12/2025
Monitoring measure 1.3	Achieve NCQA Health Equity Accreditation, previously known as NCQA Distinction in Multicultural Healthcare (MHC)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No implementation plan in place	Implementation plan created and in use as demonstrated by the initiation of NCQA Health Equity Accreditation application process started	05/2025	NCQA Health Equity Accreditation Plus achieved	12/2025

Activity 2 description: Meaningful Language Access (MLA) – Develop reporting to receive and share wait times and accessibility with and from providers.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Develop wait time and interpreter accessibility reports (internal & shared with providers)

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Average wait times and interpreter availability is recorded.	Internal reporting of wait time and interpreter availability created and shared.	09/2024	Wait time and interpreter availability reports created and shared with providers	12/2024
Monitoring measure 2.2	Develop Encounter-Level Reporting (received from provider EHRs)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No encounter level reporting for appointments that are cancelled or rescheduled due to a lack of interpretation services.	CHA receives reporting from 40% of EHR using providers	12/2024	CHA receives reporting from 100% of EHR using providers	12/2025

Activity 3 description: Workforce Development – Implement a monthly health equity training and education program for staff

☒ Short term or ☒ Long term

Monitoring measure 2.1	Develop and implement quarterly health equity training program			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Training occurs as needed annually	Program developed and implemented	09/2024	At least 1 training completed in 2024	12/2024
Monitoring measure 2.2	Monthly health equity trainings completed			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Training occurs as needed annually	Twelve trainings completed (one per month)	09/2024	Same as target	12/2024

A. Project title: Medical Dental Integration

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

If continued, insert unique project ID from OHA: 364

B. Components addressed

1. Component 1: Oral health integration
2. Component 2 (if applicable): Choose an item.

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

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

Continued projects

7. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** In 2023, Cascade Health Alliance (CHA) and Konnect Dental Kare (KDK) made significant strides in integrating medical and dental health services within Klamath County. Through community outreach initiatives such as "Free Dental Days," KDK provided preventative dental care to over 2,200 community members, primarily children aged 1-14, in remote areas. This effort was supported by a mobile dental operatory, enhancing service delivery in underserved regions. Additionally, Sanford Children's Clinic, The Children's Clinic of Klamath Falls, Graham Pediatrics, and Cascade East Family Practice all integrated fluoride varnish applications and oral health screenings into their services which helped in generating necessary referrals for further dental care. Despite the discontinuation of the local Southern Oregon Health Information Exchange's (HIE) referral platform, CHA aimed to overcome this through partnerships and alternative solutions, focusing on maintaining effective communication and referral processes between medical and dental providers. Additionally, REALD data indicated a stable engagement with racial minorities, though a slight decrease in services to disabled members was noted, suggesting a need for targeted improvements.
8. **Describe whether last year's targets and benchmarks were met (if not, why):** The goals for expanding dental care access and integrating services through HIE faced challenges, particularly with the extended loss of a dental provider at the OIT Dental Clinic drastically reducing the services they were able to provide and the bandwidth to move forward with HIE integration, and the discontinuation of the local HIE's referral platform. Although not all planned activities were completed due to staffing issues and increased service demands, substantial progress was made in establishing foundational elements for ongoing integration. The mobile clinic's success in exceeding dental care targets demonstrates effective strategic implementation, even as some benchmarks around HIE integration were not fully met.
9. **Lessons learned over the last year:** The past year highlighted several key lessons: The necessity of flexibility in operational strategies, especially in response to technological disruptions like the HIE platform's discontinuation. The importance of community-based outreach and mobile health solutions in addressing access barriers in rural areas. Continuous engagement with community stakeholders and regular training, as conducted by KDK with the support of the Oregon Institute of Technology, is crucial for sustaining service quality and adaptability. Developing robust alternative communication and referral systems in the absence of a traditional HIE is essential for maintaining continuity of care across healthcare disciplines. These insights will guide future initiatives, focusing on enhancing service integration and addressing the specific needs highlighted by REALD and SOGI data, ensuring that all community members receive equitable and comprehensive healthcare services.

Dental providers in CHA's network are primarily located in Klamath Falls, creating transportation challenges for residents in outlying areas. To address this, "Free Dental Days" are organized annually in the remote communities of Merrill and Malin. These events are staffed by Konnect Dental Kare (KDK), operated by an Expanded Practice Dental Hygienist (EPDH), who provides screenings and preventive services, mainly to children, through a contract with CHA. Although these clinics offer essential oral health care to individuals who might otherwise have limited access, patients still need to travel to a central location for services. This situation restricts the availability of oral health care for those living in the more isolated areas of Klamath County.

Sanford Children's Clinic and The Children's Clinic of Klamath Falls have continued to provide fluoride varnish applications and oral health screenings within their primary care offices. Both pediatric clinics received

fluoride varnish training in 2023 from Konnect Dental Kare, the Expanded Practice Dental Hygienist (EPDH) contracted by Cascade Health Alliance (CHA). These oral health screenings generate referrals to additional oral health services at the children's primary care dentist. Although these referrals are currently managed through traditional processes rather than a Health Information Exchange (HIE), they remain generally effective. In 2023 the local southern Oregon HIE ended its referral platform for clinics. While medical practices were better positioned to find a different vendor for e-referrals, this is something dentists have struggled with. Ongoing research and analysis are being conducted to identify a suitable referral system alternative.

Klamath Health Partnership (KHP), doing business as Klamath Open Door (KOD), a Federally Qualified Health Center (FQHC), continues to operate as a fully integrated clinic, offering physical, oral, and behavioral health services at a single location. For patients with significant behavioral health needs, KHP has a primary care provider co-located at Klamath Basin Behavioral Health (KBBH), a Community Mental Health Program (CMHP). This provider can assess physical and oral health needs and refer patients to KOD's main clinic for treatment if necessary. KHP remains a key example of successful integration in the region.

In 2023, Konnect Dental Kare (KDK) engaged in seven community outreach initiatives, including "Free Dental Days," where they provided preventive dental care to more than 2,200 community members—primarily children aged 1-14—in various regional locations. With grant funds provided by CHA, KDK was able to purchase a trailer and retrofit it with electrical, plumbing, and a full suite of dental equipment. This mobile Dental operatory significantly boosts KDK's capacity to offer dental services to rural members, thereby enhancing access to vital oral health care for those in remote areas who might otherwise encounter substantial barriers.

KDK's community events in 2023 included:

- Klamath Basin Potato Festival
- Merrill Dental Day
- Malin Dental Day
- Children's Learning Fair
- Sky Lakes Health Fair
- Merrill Health Fair
- Community Baby Shower

In an effort to increase access to dental services for those with disabilities, KDK routinely visited the following Skilled Nursing Facilities:

- Marquis Plum Ridge Post Acute Rehab
- Crystal Terrace of Klamath Falls
- Pacifica Senior Living Klamath Falls

KDK operates the local school sealant program and provides preventative services and screenings at all city and county schools, as well as preschools and HeadStart programs.

The Oregon Health Authority (OHA) identified three high-risk co-morbidities among Oregon Health Plan (OHP) members: hypertension, diabetes, and tobacco use. With the recent formation of a Medical-Dental Integration Partnership by the CDC's Division of Oral Health, there is growing momentum in the healthcare

community to expand screening capabilities for patients with chronic diseases. In 2023, Cascade Health Alliance (CHA) aimed to further advance Oral Health Integration through the following activities:

- Increase the use of Reliance HIE by dental clinics
- Closed-loop referrals between medical and dental providers
- KDK Partnership

Integrating all providers into the HIE aims to improve referral and screening capabilities in primary care and dental settings, allowing swift, two-way communication between both provider types. However, the discontinuation of Reliance's referral platform, mid-year caused CHA to reevaluate its strategy in integrating data sharing between provider types. This work has shifted to researching possible alternatives to an HIE, with the use of HealthyKlamathConnect.com, the local Community Information Exchange (CIE) and a possible solution for secure closed-loop referrals. This work supports the second identified activity of this project, to develop and implement workflows to improve referrals and screenings in non-traditional settings. Staffing challenges and increased demand also affected this project. The initial steps were to survey providers' ability and willingness to engage in referral activities across the medical/oral divide and demonstrate the HKC as a medium for such referrals. Although these steps were not completed in 2023, there remains a need to establish a process for, and willingness to engage in, medical care referrals originating from an oral care setting.

While progress in the HIE and referral sector was slow, efforts to help KDK grow into a more robust non-traditional dental solution for the Basin advanced rapidly. In 2023, KDK staff increased, exceeding our target for the year. Additionally, KDK strengthened relationships with several medical clinics, collaborating on Well Child Visit Days and other community events. Having already partnered with one local dental office, the goal in 2023 was to expand cooperation by adding at least one more partner dental clinic that could utilize KDK's mobile operation features. To help meet the Oral Evaluations for Persons with Diabetes OHA metric, KDK worked with Klamath Dental Center and Advantage Dental Clinic.

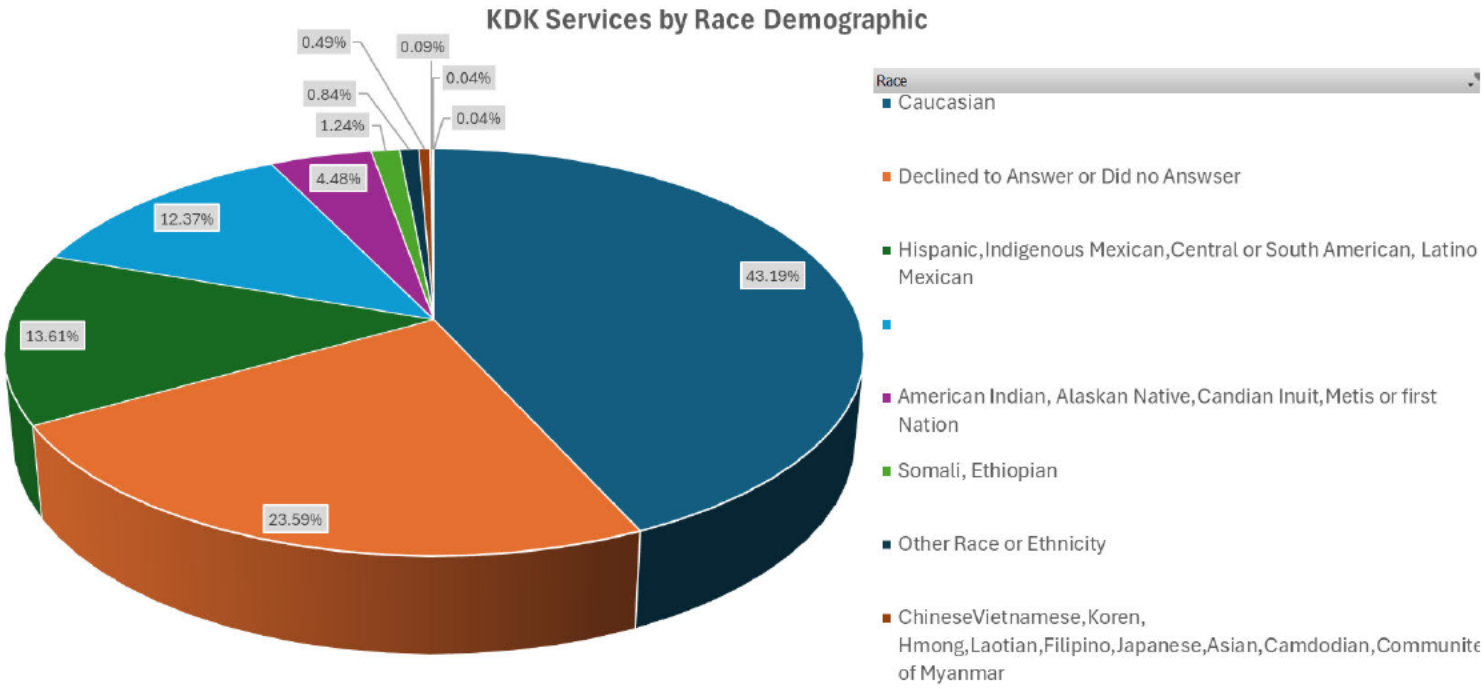
In 2023, KDK provided services to targeted demographics, including preventative dental care for members aged 1–5 and 6–14, aligning with the OHA Preventive Dental and DHS metrics. With their help, CHA surpassed the OHA benchmark by 11.6% for preventative services for kids ages 1-5 and 9.6% for kids ages 6-14.

Cascade Health Alliance (CHA) and Konnect Dental Kare (KDK) have launched a strategic initiative to utilize TeleDentistry. Planning began in May, with the initiative implemented in September. This collaboration aims to streamline the referral process to both medical and dental homes for members, expanding access to urgent dental care, especially for remote and underserved populations.

Additionally, KDK plans to partner with the Sky Lakes Oncology department to provide preventive dental services and screenings to patients undergoing chemotherapy. Oral health is crucial for cancer patients as chemotherapy can lead to complications such as mouth sores, infections, and dry mouth, which can significantly impact their overall health and treatment outcomes. By meeting members where they are during their chemotherapy treatments, this initiative helps reduce barriers to accessing essential dental care, ensuring that patients receive comprehensive support without the added stress of traveling to separate appointments. This approach not only improves their oral health but also contributes to their overall well-being during a critical period in their cancer treatment.

REALD data for KDK activities in 2023 did not indicate any trends necessitating a change in engagement strategies. While work with self-identified racial minorities increased (Figure #), engagement with disabled members decreased slightly. These variations do not appear to be significant or related to provider behavior, as preventative services were alternatively offered in SNF settings specifically for elderly and disabled individuals with mobility limitations. These services were offered during general community outreach and were not necessarily encountered for data capturing by CHA. In 2024, CHA will develop a plan to use sexual orientation and gender identity (SOGI) data to identify health equity disparities.

Figure 6



D. Brief narrative description

1. **Project population:** The project population primarily consists of members within the Cascade Health Alliance (CHA) network, focusing on individuals in rural areas who face barriers to accessing healthcare services. This population includes diverse groups with varying needs related to oral health, chronic disease management, and behavioral health issues, emphasizing the need for integrated care across primary care, oral health, and behavioral health services.
2. **Intervention (address each component attached): Data Sharing and Referral System Improvements:** CHA aims to enhance healthcare through Healthy Klamath Connect. The goal is to streamline referrals and improve the coordination of care by: Developing methods to showcase the platform's potential in improving workflows in non-traditional care settings. Documenting effective usage paths for new user onboarding. Increasing platform adoption by identifying and engaging providers who can perform screenings and manage referrals efficiently. **Expansion of Services and Addressing Staffing Challenges:** To overcome the staffing challenges noted in 2023, CHA plans to strengthen its partnership with local oral health providers and leverage increased staffing to continue integrating Konnect Dental Kare (KDK). Efforts will include Utilizing KDK's dental trailer to extend oral health care beyond

traditional settings, making it a versatile tool for disease screening and referrals. Exploring funding opportunities to expand KDK's capabilities, potentially co-locating dental resources within primary and specialty care settings to enhance service accessibility. **Prioritization of REALD and SOGI Data:** CHA is committed to enhancing health equity by prioritizing the collection and analysis of REALD (Race, Ethnicity, Age, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data. This initiative aims to: Identify and address health disparities within the network's diverse patient population. Ensure that services are culturally sensitive and inclusive, meeting the specific needs of all community members, regardless of their background or identity. By improving data systems and fostering collaborations with providers, CHA strives to develop an integrated and effective healthcare delivery system that aligns with the diverse needs of Klamath County residents. These strategic interventions are designed to progress towards health equity and enhance access to quality care for every individual served by CHA.

To promote the value of the HKC, CHA will develop methods to demonstrate how the platform can improve workflows and provide better care through seamless referrals between different provider types. This will involve partnering with existing users of the platform to document effective use cases and workflows, which can be highlighted during provider onboarding. Additionally, CHA will identify providers capable of referring to, and receiving referrals from, other users of the platform as its adoption increases.

CHA's partnership with KDK will continue to grow and will possibly be the grounds for modeling successful use of HKC for referrals to different providers. KDK's ability to be both flexible and mobile will serve not only as a viable resource for oral health care outside of traditional dental offices but also as a means for disease screenings and referrals to and from medical providers. CHA will explore funding opportunities for the expansion of KDK and the implementation of their services in partnership with local oncology providers, whether as a mobile dental resource or a dental resource co-located in a primary care setting.

CHAs dedication, to merging physical and oral health services by improving data sharing and coordinated care is clear in our partnerships and innovative strategies. Through the utilization of the HKC platform we aim to simplify processes, facilitate referrals and enhance health outcomes within our network of providers. The expansion of Konnect Dental Kares (KDK) services and their integration with primary care facilities demonstrates our commitment to providing comprehensive healthcare for all individuals, especially those residing in rural areas.

In the future CHA will give priority to gathering and analyzing REALD and SOGI data to recognize and tackle health disparities. This emphasis ensures that our services are fair, culturally responsive, and inclusive of all individuals regardless of their race, ethnicity, language, disability status, sexual orientation, or gender identity. By improving our data systems and collaborating with providers CHA aims to establish an integrated and efficient healthcare delivery system that meets the diverse needs of Klamath County residents. Through these initiatives we aim to progress towards achieving our objectives of health equity and enhancing access to quality care, for every individual we assist.

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

Activity 1 description: **HIE/CIE Integration:** Dental providers integrated into Health Information Exchange (HIE)

☐ Short term or ☒ Long term

Monitoring measure 1.1	Identify alternative program to local Health Information Exchange

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No program identified	2 alternatives to local HIE identified	12/2024	1 alternative to local HIE selected for implementation	03/2025

Activity 2 description: HIE/CIE Screenings & Referrals: Development of workflow for preventive medical screenings and referrals via HIE alternative program by oral health providers.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Workflow for external referrals researched and documented.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Referral workflow not created	Referral workflow researched with existing providers and documented	03/2025	Referral workflow added to dental HIE/CIE onboarding process	06/2025
Monitoring measure 2.2	Oral healthcare ability to perform medical screenings.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
% Of Oral Healthcare providers able to deliver screenings is unknown.	Survey Oral Healthcare providers on ability and willingness to perform medical screenings.	09/2024	At least 50% of Oral Healthcare providers able to perform medical screenings.	12/2025
Monitoring measure 2.3	Primary Care Providers able to receive and act on referrals from Oral Healthcare providers.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
% Of Primary Care Providers able to receive referrals from Oral Healthcare is unknown.	Survey Primary Care Providers on ability and willingness to receive and act on referrals from Oral Healthcare.	09/2023	At least 70% of Primary Care Providers able to receive and act on Oral Healthcare referrals.	12/2024

Activity 3 description: Expand Klamath Dental Kare (KDK) as a mobile, non-traditional setting, oral healthcare resource.

☐ Short term or ☒ Long term

Monitoring measure 3.1	KDK Primary Care Partner Organizations			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

2 primary care partners	1 additional primary care partner up to 3	12/2024	2 additional primary care partners up to 4	12/2025

A. Project title: Comprehensive PCPCH Plan

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

If continued, insert unique project ID from OHA: 365

B. Components addressed

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

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

Continued projects

10. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** CHA has made notable strides in its PCPCH: Tier Advancement and PCPCH: Member Enrollment initiatives. Currently, 95% of the 25,627 members with physical coverage are assigned to a PCPCH, resulting in an improved weighted score of 83% in 2023, up from 79% in 2022. This progress not only maintains a level above the statewide average of 76% reported in 2020 but also reflects the effectiveness of the comprehensive PCPCH plan in place. Additionally, CHA is enhancing its data analysis efforts with a health equity lens, particularly focusing on REALD & SOGI data, to ensure inclusivity and high-quality care across diverse member demographics.
11. **Describe whether last year's targets and benchmarks were met (if not, why):** The targets and benchmarks for the comprehensive PCPCH plan development and implementation were not met as planned in 2023 and have been extended into 2024. The target for member enrollment and weighted score also fell short of the baseline goal of 85%, primarily due to the post-pandemic surge in utilization and staffing challenges. These factors strained the network and impacted the ability to meet these targets.
12. **Lessons learned over the last year:** Several key lessons emerged from the past year's efforts: **Adaptability in Resource Allocation:** The necessity to adapt resource distribution in response to fluctuating clinic capacities and staffing levels has been crucial. **Importance of Local Engagement:** Engaging smaller clinics, particularly in remote areas, remains challenging. Tailored strategies to increase participation in learning collaboratives need to be developed. **Enhanced Data Utilization:** Incorporating a health equity lens into PCPCH data analysis has proved beneficial in identifying and addressing disparities. This approach will be vital in refining health services and ensuring equitable care across all demographics. **Strategic Communication:** The use of CHA's messaging system and social media to emphasize preventative care and local events has effectively supported the population during capacity challenges, highlighting the importance of communication in healthcare management. These insights will guide future strategies and adjustments to ensure continued improvement in member care and performance metrics.

For the PCPCH: Tier Advancement and PCPCH: Member Enrollment components, CHA has aligned its Improve Member Experience through PCPCH Tier Advancement performance improvement project (PIP) with

the Comprehensive PCPCH Plan TQS project. Beyond the TQS and PIP initiatives, CHA continues to prioritize Patient-Centered Primary Care Home (PCPCH) clinics when assigning new and unassigned members to a primary care provider.

To encourage clinics to achieve higher tier levels, CHA has maintained value-based payments for tier 3 and above. CHA also adheres to established standards to ensure members receive integrated, culturally, and linguistically appropriate patient-centered care and services (including physical, behavioral, and dental care) as outlined in its Patient Centered Primary Care Home Policy and Procedure (see attached).

A post-pandemic surge in utilization stressed the CHA network, pushing many clinics to capacity and affecting the ability to assign members to preferred high-PCPCH-tier providers early 2023. However, the member assignment expansion of one PCPCH clinic, and another clinic's tier advancement led to an increase in the weighted score to 83%, compared to 79% (2022). Of the 25,627 members currently enrolled with physical coverage, 95% (24,344) are assigned to a PCPCH. Despite this year's challenges, it remains above the statewide average of 76% reported in 2020.

2024 Monitoring Activity Updates:

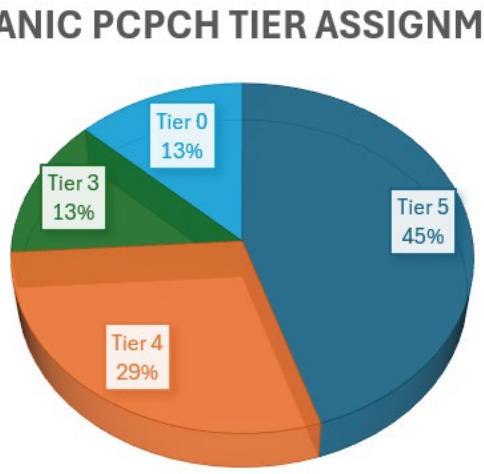
- **Activity 1 (Development and implementation of PCPCH comprehensive plan and learning collaborative):** The 2023 target and benchmark dates for PCPCH comprehensive plan development and implementation will be re-extended into 2024.
- **Activity 2 (Member enrollment and weighted score):** Target missed at end of 2023. CHA will work towards regaining baseline of 85% during 2024.
- Progress is further explained below.

Due to geographic location, smaller clinics have shown little interest in participating in a learning collaborative aimed at improving PCPCH performance. Limited staffing and a challenging labor market have strained project work, with member experience and metric performance taking higher priority. As CHA and local clinic staff work to fill open positions and enhance operational efficiency, efforts to revise this plan will continue into 2024.

Despite these challenges, CHA's provider network achieved two significant successes: one local clinic doubled its member enrollment capacity, and another clinic attained a Tier 5 status. These achievements have alleviated pressure on the network and improved overall statistics. In response to capacity challenges, CHA's messaging system and social media presence emphasized preventative care and local events to efficiently support the population.

Member assignment to PCPCH clinics has shown impressive growth, achieving a current weighted score of 83%. We are now enriching our analysis of PCPCH assignment data with a health equity lens to ensure inclusivity across race, ethnicity, language, and disability (REALD). Notably, a significant portion of the Hispanic population, 45%, has a PCP assignment at a Tier 5 clinics (Figure 7), reflecting our commitment to ensuring equitable access to high-quality care. We will continue to refine our strategies to further advance health equity. As we gather more data, it will be seamlessly integrated into our ongoing analysis of member assignments, PCPCH status, and REALD and SOGI data, supporting our mission to continuously improve care for all members.

Figure 7



D. Brief narrative description

1. **Project population:** The project focuses on the population enrolled in CHA's Patient-Centered Primary Care Home (PCPCH) clinics, particularly aiming at those eligible for care under PCPCH criteria. Currently, 95% of these members are already assigned to PCPCH clinics. Special attention is given to members identified with considerations under Race, Ethnicity, Language, and Disability (REALD), as well as Sexual Orientation and Gender Identity (SOGI), ensuring that these populations receive equitable and high-quality care at the highest-tier clinics available.
2. **Intervention (address each component attached):** **Tier Advancement and Member Enrollment:** The comprehensive PCPCH plan will continue to focus on advancing tiers and enrolling members in PCPCH clinics. The priority for 2024 is to assist high-tier clinics in expanding their staffing capacities to accommodate new members. This will include targeted support to Tier 3 and 4 clinics and initiatives to bring non-PCPCH primary care clinics up to PCPCH standards. **Educational and Relationship-Building Efforts:** CHA plans to enhance relationships with non-PCPCH clinics by educating them about the benefits of having a PCPCH designation. This will include providing assessment tools to determine clinic readiness for tier advancement and continuous education about the integral components of PCPCH standards. **Technical Assistance:** Ongoing technical assistance will be provided to clinics facing challenges in meeting PCPCH standards. This support aims to overcome barriers through direct interventions, resources, and guidance tailored to each clinic's specific needs. **Data Monitoring and Reporting:** Monitoring of PCPCH and member data will be enhanced to better understand care patterns and address any disparities. This year, CHA introduced the collection of SOGI data from members, which, alongside REALD data, will be used to create comprehensive quarterly reports. These reports will stratify PCPCH details by REALD and SOGI metrics to guide network management and member enrollment decisions more effectively. The current monitor-based process for identifying REALD data is being developed into a more systematic reporting tool to ensure all decisions are data-informed and equitable. These interventions are designed to reinforce the infrastructure of PCPCH facilities, ensuring that all members, especially those from diverse and often marginalized backgrounds, receive the care they need in a manner that respects their unique health requirements.

CHA will continue developing a comprehensive PCPCH plan focused on tier advancement and member enrollment. With 95% of eligible members currently assigned to PCPCH clinics, our 2024 priority will be to support high-tier PCPCH clinics in regaining the staffing capacity needed to accept new members. Following this, we will prioritize establishing care for members with Race, Ethnicity, Language, and Disability (REALD)

and Sexual Orientation and Gender Identity (SOGI) considerations at the highest-tier clinics available, ensuring equality of care among CHA's members.

The project will target current Tier 3 & 4 PCPCH clinics and non-PCPCH primary care clinics contracted with CHA. Efforts will include building relationships with non-PCPCH clinics, educating practices on the benefits of tier advancement, and providing assessment tools to determine program readiness. CHA will continue offering technical assistance (TA) to any clinic needing help overcoming barriers to meeting PCPCH standards.

Additionally, CHA will monitor PCPCH and member data to enhance our understanding of population care and proactively address identified disparities. With the initiation of gathering Sexual Orientation and Gender Identity (SOGI) data from members this year, CHA will implement efforts to create robust quarterly reports that stratify PCPCH details by REALD and SOGI when available. Currently, the process only identifies REALD data and is monitor-based, but CHA is working to develop this into a regular report to inform decisions in network management and member enrollment.

Supporting Documents

PCPCH Comprehensive Plan
PCPCH Policy & Procedure

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

Activity 1 description: Develop and implement PCPCH Comprehensive Plan

☒ Short term or ☐ Long term

Monitoring measure 1.1	Status of PCPCH Comprehensive Plan			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Update PCPCH Comprehensive Plan	Finalized PCPCH Comprehensive Plan	06/2024	PCPCH Comprehensive Plan Implemented and Established	12/2024

Activity 2 description: Increase member enrollment in higher tiered PCPCH clinics through supporting 4 Star clinics advancement to 5 star and working with non-PCPCH clinics to become PCPCH clinics.

☐ Short term or ☒ Long term

Monitoring measure 2.1	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)**
83% (weighted score)	85% (weighted score)	12/2024	86% (weighted score)	12/2025
Monitoring measure 2.2	Engagement with non-PCPCH clinics.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 monthly engagement	Monthly engagement	07/2024	At least 1 of 3 non-PCPCH clinics	12/2024

meetings with non-PCPCH clinics	meetings established with at least 1 of 3 non-PCPCH clinics		recognized as PCPCH	
Monitoring measure 2.3	PCPCH Health Equity Data (REALD+SOGI)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Data reviewed ad-hoc	Create dashboards and reporting that can be available quarterly.	12/2024	Incorporate REALD & SOGI data into quarterly dashboards to identify disparities.	12/2025

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

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

If continued, insert unique project ID from OHA: 368

B. Components addressed

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

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

Continued projects

13. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** Cascade Comprehensive Care (CCC), in partnership with ATRIO Health Plans, managed the care for 140 full benefit dual eligible (FBDE) long-term services and supports (LTSS) members within Klamath County's coordinated care organization (CCO) during 2023. This population was actively managed under both CHA and ATRIO's Special Needs Plan (SNP) focusing on members identified as LTSS recipients. Initiatives to enhance data collection and utilization, specifically involving race, ethnicity, language, disability (REALD), and sexual orientation and gender identity (SOGI), began to be incorporated- aiming for a more comprehensive understanding and stratification of the LTSS population to identify disparities and service gaps.
14. **Describe whether last year's targets and benchmarks were met (if not, why):** In 2023, CCC and ATRIO set a target for 89% (125 members) of FBDE SNP LTSS members to complete a Health Risk Assessment (HRA). This target was successfully met. The systematic approach included mailed HRAs and up to three follow-up calls for non-compliance within 30 days, ensuring robust member engagement and care plan tailoring. However, the goal to create a full LTSS FBDE quality dashboard was not met due to technical challenges and staffing issues, leading to a revised approach of developing a phased dashboard based on identified measures.
15. **Lessons learned over the last year:** Several critical lessons emerged from the experiences of 2023: **Integration Challenges:** The lack of interoperability between CHA and ATRIO's care management platforms highlighted significant inefficiencies. This issue underscored the necessity for compatible IT

solutions to facilitate smoother information sharing and case management. **Staff Training and Understanding:** Initial misunderstandings of project goals and outdated workflows, coupled with a steep learning curve for new staff, significantly hampered progress until late 2023. These challenges emphasized the need for ongoing staff training and clear, updated procedural documentation. **Collaborative Enhancements:** The successful collaboration with Aging and People with Disabilities (APD) via bi-weekly meetings and the implementation of system flags to identify LTSS members in case management systems showcased effective strategies to enhance service delivery and member tracking. **Strategic Data Use:** The initiation of REALD and SOGI data collection planning revealed the importance of targeted data strategies to address health disparities effectively and adapt care practices to meet diverse member needs more accurately. Moving forward into 2024, CCC and ATRIO are well-positioned to leverage these insights to enhance data sharing, streamline care coordination processes, and improve health outcomes for the LTSS FBDE population. Efforts will continue to focus on refining the phased quality measure dashboard and expanding data-centric models to better manage and understand the complexities of the LTSS populations.

Cascade Comprehensive Care (CCC) is a healthcare management company operating Klamath County's Coordinated Care Organization (CCO), CHA, and serves as a local administrator for ATRIO Health Plans (ATRIO), a Medicare Advantage (MA) plan. In 2023, CCC, in collaboration with ATRIO Corporate, managed care for 140 full benefit dual eligible (FBDE) long-term services and supports (LTSS) members who were enrolled in both CHA and ATRIO's Special Needs Plan (SNP). These members were identified as LTSS and received care simultaneously under both plans.

The targeted FBDE SNP LTSS population, along with the broader FBDE SNP population, was managed according to the Model of Care (MOC) outlined for all FBDE members. Health risk assessments (HRAs) were conducted using two methods:

1. Mail: Members received HRAs by mail, with instructions to complete and return them.
2. Telephone: Members had the option to call in and complete the HRA over the phone.

If an HRA was not completed within 30 days, up to three follow-up phone calls were made to encourage members to complete the assessment.

Regardless of HRA completion, all members received a care plan tailored to their health status, which included specific health goals. Additional follow-up appointments with their assigned nurse case manager were scheduled within three to six months to ensure ongoing support and care coordination.

CHA emphasizes the inclusion of caregivers in interdisciplinary team (IDT) meetings, care plan goal setting, and discussions to enhance the support provided to members. This collaborative approach ensures that caregivers are actively involved in the member's care process.

CHA collaborates with Aging and People with Disabilities (APD) and Developmental Disability Services (DDS) to request and review caregiver service plans. This review helps identify and address any unmet needs, ensuring comprehensive support for both members and their caregivers.

This structured and collaborative approach aims to improve health outcomes and care management for the FBDE SNP LTSS population, leveraging interdisciplinary teamwork and continuous engagement with members and caregivers.

Although Cascade Comprehensive Care (CCC) and ATRIO Health Plans (ATRIO) regularly collaborate to meet the needs of LTSS members and made significant strides toward improvement; during 2023 the infrastructure to collaborate consistently and efficiently across lines of business remained inefficient. The care management platforms of CHA and ATRIO are not compatible, making it challenging for each entity to access progress notes, care plans, or confirm active management of members by either organization. Due to this lack of compatibility, information sharing is labor-intensive. Communication between departments managing LTSS is continuous and hands-on. While CHA staff document the Health Risk Assessment (HRA) in Essette (CCC's EHR), ATRIO staff must also complete a documentation note in their respective EHR (Acuity) for FBDE members.

During 2023, the project faced significant challenges. There was a lack of understanding of the project, outdated workflows and flowcharts, insufficient staff, and a steep learning curve for new staff, all of which halted progress until late 2023. However, CCC and ATRIO have since gained a thorough understanding of the project and have designated staff to exclusively manage these cases, including two registered-nurses (one CHA, one ATRIO) and a case manager who monitors transfers of care, discharges from short-term and long-term hospital and institutional stays, and generates member care plans as needed. Both CHA and ATRIO now monitor members at higher risk for readmissions and refer them to additional case management as appropriate. By 2024, both organizations aim to have systems in place to monitor transitions of care plans and workflows to reduce hospital readmissions.

In late 2023, CCC and ATRIO undertook a full revamp of the project. Understanding the LTSS FBDE population was the first step, followed by an in-depth review to create improvements and replace previous workarounds with efficient workflows. This included enhancing the integration of DSNP Case Management. CHA and ATRIO have better aligned member needs with the appropriate type of case management: ATRIO provides long-term, low-risk case management, while CHA offers acute, high-risk case management through Intensive Community Care Management (ICCM). Additionally, CHA and ATRIO established a similar partnership and process with Aging and People with Disabilities (APD).

In 2023, CHA began collaborating with APD through bi-weekly meetings to assist members, guided by the Memorandum of Understanding (MOU) with APD. The MOU supports collaboration and information sharing between APD and CHA for members with LTSS, enhancing the integration of services and improving member experience. CHA implemented a flag in Essette (LTSS program), to allow CHA and ATRIO Case Managers to easily identify members receiving LTSS. ATRIO added a similar LTSS flag to its case management system, improving the efficiency of identifying LTSS members. Case Managers can now use Essette to see all members who are enrolled, in process, referred, or have an inpatient case status.

Progress on this project accelerated in late 2023 due to a clearer understanding of LTSS and the restructuring of workflows. Data sharing, processes, and communication improved significantly. Although this project focuses on LTSS members with SHCN, the processes ensure that any FBDE SNP member with SHCN receives care coordination, care planning, and management of care transitions, with the goal of appropriate access to care and improved health outcomes.
A collaborative care workflow was finalized to document the current process. CHA and ATRIO Case Managers now have an efficient process for collaborating on shared members. APD sends CHA a monthly LTSS report, which is then filtered to include only ATRIO members and shared with ATRIO. This allows both CHA and ATRIO to identify FBDE LTSS members. Due to bandwidth constraints and the need for system enhancements, automated data and information sharing have not yet been implemented. However, data capture for Annual IDT meetings by CHA, ATRIO, and APD/AAA teams for LTSS SNP FBDE members has significantly improved in 2024.

In 2023, CHA and ATRIO utilized the LTSS report from APD to identify members in need of case management services. Health Risk Assessments (HRAs) were used to prioritize members with the highest needs, to understand them holistically, and to update care plans accordingly. Of the 140 FBDE SNP LTSS members, 89% (125 members) completed an ATRIO HRA in 2023, meeting the target and setting the stage for an updated target in 2024. The total number of LTSS members is expected to increase due to the OHA 834 file. In 2023, care plans were regularly updated every 90 days.

Due to the challenges mentioned, CHA and ATRIO did not create a full LTSS FBDE quality dashboard in 2023 as originally planned. However, CHA developed a three-phased plan to develop the dashboard based on the measures identified in 2023. The plan includes:

- Phase 1 EHR Measures: Screening for Depression and Follow-Up Plan, Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control, Smoking Prevalence, and Drug or Alcohol Misuse Screening (SBIRT) (Figure #).
- Phase 2 Claims Measures: All-cause readmissions, Ambulatory care: Avoidable emergency department utilization, Disparity Measure: Emergency Department Utilization among Members with Mental Illness.
- Phase 3 Prevention Quality Indicators (PQI) Measures: PQI 01: Diabetes short-term complication admission rate, PQI 05: COPD or asthma in older adults' admission rate, PQI 08: Congestive heart failure admission rate, and PQI 15: Asthma in younger adults' admission rate.

Figure 8

2023 LTSS FBDE EHR Metrics

			2022 OHA EHR Metrics		2023 OHA EHR Metrics		LTSS Difference	LTSS % change
			CHA Overall	LTSS FBDE	CHA Overall	LTSS FBDE		
Starting 2023 Population	140	Smoking Prevalence	25.30%	15.79%	26.30%	17.41%	1.62%	10.26%
Final 2023 Population		Diabetes Poor Control	27.30%	21.88%	27.00%	12.96%	-8.92%	-40.75%
		Depression Screening	35.40%	44.83%	37.30%	32.87%	-11.96%	-26.68%
Number of Cohort with an active Atrio HRA	125	SBIRT Screening (Rate 1)	48.10%	57.14%	56.00%	61.00%	3.86%	6.75%
		SBIRT Intervention (Rate 2)	62.60%	0%*	46.50%	42.86%	0%*	N/A

*This measurement had a very small denominator in 2022 & 2023

Additional quality measures may be added upon completion of Phase 3. CHA has been working with primary care providers to retrieve member-level outputs from EHR sources, facilitating the necessary data work for this LTSS project and opening opportunities for additional exploration of priority populations (Figure #). In 2024, CHA will develop a comprehensive plan to collect and utilize data on race, ethnicity, language, and disability (REALD), as well as sexual orientation and gender identity (SOGI), during member onboarding. This initiative aims to stratify LTSS data to identify disparities and gaps across the LTSS population, ensuring more equitable and effective care.

Figure 9

Race	LTSS Volume	LTSS %	Overall CHA %
Caucasian	809	73.51%	53.45%
Declined to Answer or Did no Answser	157	13.65%	29.39%
Hispanic,Indigenous Mexican,Central or South American, Latino Mexican	51	4.78%	10.63%
American Indian, Alaskan Native,Candian Inuit,Metis or first Nation	37	3.59%	2.99%
Somali, Ethiopian	21	1.99%	1.39%
Other Race or Ethnicity	12	1.10%	1.05%
Blank	10	1.00%	0.06%
Chinese, Vietnamese, Korean, Hmong, Laotian, Filipino, Japanese, Asian, Camdodian, Communites of Myanmar	1-5	*Suppressed*	*Suppressed*
Grand Total	**1101**	**100.00%**	**100.00%**

To protect confidentiality, we do not show communities with fewer than 50 eligible members. Member numerator counts of five or less are suppressed and published as "1-5". Numerator counts of greater than five are published as the number. Demographic categories with no numerators are published as zero.

The improvements and collaborative efforts in late 2023 and into 2024 have laid a strong foundation for better managing LTSS members. By addressing the inefficiencies and enhancing data sharing and care coordination processes, CCC and ATRIO are well-positioned to achieve significant health outcomes for the LTSS FBDE population.

D. Brief narrative description

1. **Project population:** The project population for Cascade Health Alliance (CHA) in collaboration with ATRIO includes members who are in need of or currently receiving Medicaid-funded Long-Term Services and Supports (LTSS). This includes those covered under Medicaid as primary beneficiaries or as full benefit dual eligible (FBDE) individuals. The population specifically targets members with: High healthcare needs. Multiple chronic conditions. Mental illness or substance use disorders. Functional disabilities or those living in social conditions that increase their risk of developing functional disabilities. Criteria that meet the Special Health Care Needs (SHCN) as defined by the Oregon Administrative Rules (OARs). These members are characterized by a complex array of healthcare requirements and socioeconomic factors that necessitate a comprehensive and integrated approach to their care.
2. **Intervention (address each component attached): Workflow and Coordination: Annual Workflow Updates:** CHA and ATRIO ensure that the processes and workflows for service provision and coordination are reviewed and updated annually. This includes the identification of care barriers, coordination with primary care providers (PCPs) and other relevant parties, adherence to medical treatment plans and medication regimens, provision of disease-specific education, and addressing social determinants of health. **Comprehensive Data Monitoring and Analysis Plan:** This plan encompasses monitoring outreach efforts, member engagement in services, service provision, active case management, Emergency Department (ED) utilization, depression screening and follow-up, all-cause readmissions, and the health outcomes related to chronic diseases such as diabetes, congestive heart failure, asthma, and COPD. **Health Outcomes and Disparities: Improving Health Outcomes and Addressing Disparities:** By identifying opportunities for improvement, CHA and ATRIO aim to refine health outcomes and target health disparities within the LTSS population, employing a data-centric approach to measure effectiveness and guide interventions. **Staff Training and Information Accessibility: Staff Training:** A formal training curriculum based on ATRIO's Special Needs Plan (SNP) Model of Care (MOC) is developed to ensure that staff are well-equipped to manage the complex needs of the LTSS population. **Information Sharing:** Mutual accessibility of all necessary member information and reporting between CHA and ATRIO is maintained to support effective case management and coordination. **Quality Measure Development: Quality Measure Dashboard:** The

development of a quality measure dashboard that focuses on Phase 1 LTSS health outcome measures is a key intervention for 2024. This dashboard will facilitate the transition of the project to a data-centric model, aligning with LTSS MOU reporting measures. **Case Management and Care Coordination: Enrollment in Case Management Programs:** Members identified with specific needs are continuously enrolled in appropriate case management programs, which provide a person-centered, holistic plan of care developed in collaboration with the member and/or caregiver. **Interdisciplinary Team (IDT) Meetings:** Monthly IDT meetings involve a comprehensive team including the member and/or designated caregiver, PCP, nurse case manager, and other relevant providers like long-term care community nursing, APD, DDS, adult foster homes, and assisted living facilities. These meetings ensure appropriate coordination and provision of services, addressing access to care, reduction of care barriers, resource identification, and polypharmacy issues. **Community Resource Integration: Healthy Klamath Connect:** Members are connected to local resources through Healthy Klamath Connect, a Community Information Exchange with a closed-loop referral system ensuring members receive services for their social needs. **Inclusive Data Collection: Collection of SOGI Data:** In 2024, CHA plans to develop a strategy to collect data on sexual orientation and gender identity during member onboarding. This initiative is aimed at stratifying LTSS data to identify and address disparities and gaps, promoting more equitable and effective care across the LTSS population. These interventions collectively aim to enhance the health management of the LTSS population by improving data capture, standardizing communication, and streamlining care coordination, thereby increasing the overall effectiveness of the healthcare services provided.

In collaboration with ATRIO, Cascade Health Alliance (CHA) will continue to implement the documented comprehensive and integrated collaborative care coordination workflow, which includes the following elements:

- Members in need of or currently receiving Medicaid-funded LTSS services, whether Medicaid primary or FBDE covered.
- Members with high healthcare needs, multiple chronic conditions, mental illness or substance use disorders, functional disabilities, or those living with health or social conditions that place them at risk of developing functional disabilities.
- LTSS members who meet the Special Health Care Needs (SHCN) population criteria as defined by the Oregon Administrative Rules (OARs).
- Annual updates of current processes and workflows for service provision and coordination, including:
    - Identification of barriers to care.
    - Coordination with the member's primary care provider (PCP) and other relevant parties.
    - Compliance with medical treatment plans and medication regimens.
    - Disease-specific education and identification of social determinants of health needs.
    - Follow-up and monitoring of members.
- Comprehensive data monitoring and analysis plan, including:
    - Outreach efforts and engagement of members in services.
    - Services provided and members actively case managed.
    - Emergency Department (ED) utilization.
    - Depression screening and follow-up.
    - Plan all-cause readmissions.
    - Chronic diseases (e.g., diabetes, congestive heart failure, asthma, COPD) and related health outcomes.
- Identification of opportunities to improve health outcomes and address health disparities.
- Development of a formal staff training curriculum based on ATRIO's Special Needs Plan (SNP) Model of Care (MOC).

- Ensuring mutual accessibility to all necessary member information and reporting.

Streamlined processes will enhance data capture, member contact, LTSS screening, and care coordination. These efforts will standardize communication, reduce all-cause readmissions, increase depression screening and follow-up, decrease avoidable emergency room utilization, and improve health outcomes. CHA and ATRIO will develop methods to quantify disease prevalence across the member population, guiding targeted health interventions to improve outcomes.

In 2024, LTSS efforts will focus on aligning with LTSS MOU reporting measures and developing a quality measure dashboard. Phase 1 of the LTSS dashboard will concentrate on health outcome measures, transitioning the project to a data-centric model.

CHA and ATRIO will continue to enroll identified members in appropriate case management programs. These programs will address care coordination needs with a person-centered, holistic plan of care developed in collaboration with the member and/or caregiver. Monthly Interdisciplinary Team (IDT) meetings will review care plans to ensure appropriate coordination and provision of services.

Interdisciplinary care teams will include providers relevant to the member's healthcare needs, and at a minimum, the member and/or designated caregiver, primary care provider, and nurse case manager. Additional team members may include long-term care community nursing (LTCCN) services, Aging and People with Disabilities (APD), Developmental Disability Services (DDS), adult foster homes, and assisted living facilities. The team will address member access to appropriate providers (primary health, specialty, behavioral health, and dental providers), reduction in barriers to care, identification of local resources, and polypharmacy concerns.

Members are connected with local resources through Healthy Klamath Connect (Community Information Exchange), which has a closed-loop referral system to ensure members receive services for social needs.

In 2024, CHA will develop a plan to collect sexual orientation and gender identity (SOGI) data during member onboarding. This plan aims to stratify LTSS data to identify disparities and gaps across the LTSS population, ensuring more equitable and effective care.

Supporting Documents

Health Promotion and Prevention Policy and Procedure
ATRIO CHA Collaborative Workflow

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

Activity 1 description: Enhance current infrastructure by adding REALD and SOGI data to improve streamlined care coordination

☐ Short term or ☒ Long term

Monitoring measure 1.1	Improve data disparities and information sharing for streamlined care coordination			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
More consistent data and information sharing through report ingestion	Create dashboards and reporting that can be available quarterly.	12/2024	Incorporate REALD & SOGI data into quarterly dashboards.	12/2025
Monitoring measure 1.2	Utilize IDT meetings as outcome measure to demonstrate success of an enhanced infrastructure for comprehensive collaborative care coordination which includes data and information sharing. This aligns with the CCO 2.0 Deliverable CCO-APD/AAA MOU Summary Annual Report.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of Annual IDT meetings completed by CHA/ATRIO-APD/AAA teams for LTSS SNP FBDE members included REALD & SOGI data	50% of Annual IDT meetings completed by CHA/ATRIO-APD/AAA teams for LTSS SNP FBDE members	12/2024	100% of Annual IDT meetings completed by CHAATRIO-APD/AAA teams for LTSS SNP FBDE members	12/2025

Activity 2 description: Prioritize high-needs LTSS members and holistically understand all LTSS members.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Increase completion rate of annual HRA screenings.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
89% (125 of 140 members) of FBDE SNP LTSS members completed an ATRIO Health Risk Assessment (HRA) in 2023	95% of FBDE SNP LTSS members complete or update their HRA	12/2024	Same as target	Same as target
Monitoring measure 2.2	For LTSS members receiving case management, care plans are regularly updated and shared with all relevant parties. Care plan completion time for this measure is based on Medicaid (CHA) requirements since CHA is held to a stricter timeline than ATRIO. CHA must complete care plans yearly while ATRIO must complete them every six (6) months.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0% of care plans	50% of care plans	07/2024	100% of care plans	12/2024

for high risk LTSS SNP FBDE members receiving case management were updated and shared with all relevant parties.	for high risk LTSS SNP FBDE members receiving case management updated and shared with all relevant parties		for high risk LTSS SNP FBDE members receiving case management updated and shared with all relevant parties	

Activity 3 description: Utilize current and new processes to improve data capture and reporting for quality, health outcome, and other measures specific to the LTSS SNP FBDE population to inform quality improvement and care coordination efforts, beginning with the following:

- 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)
- Chronic diseases (including, but are not limited to, diabetes, congestive heart failure, asthma, and COPD) and complications of and health outcomes related to those chronic diseases.

CHA will utilize data from multiple sources, including, but are not limited to, HRAs, claims, Collective Medical, Reliance, PRM Analytics, and LTSS reports from APD to improve health outcomes of the LTSS SNP FBDE population.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Dashboard creation.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CHA created a draft dashboard for phase 1 measures	Create and finalize dashboard with phase 1 and phase 2, and phase 3 data	07/2024	Create and finalize dashboard to include phase 3 data	12/2024
Monitoring measure 3.2	Current rate maintained or improved for Screening for Depression and Follow-Up Plan OHA Incentive Metric for LTSS Population (aligns with LTSS MOU Reporting)			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
32.87% FBDE SNP LTSS members were screened for depression and had a follow-up plan if needed	Increase Depression Screening & Follow Up rate by 12% for FBDE SNP LTSS members	12/2024	Increase Depression screening rate for FBDE SNP LTSS members to better than the 2025 OHA CHA Improvement Target for the	12/2025

			Depression Screening measure.	

A. Project title: Holistic Diabetes Management

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

If continued, insert unique project ID from OHA: 366

B. Components addressed

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

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

Continued projects

16. **Progress to date (include CCO- or region-specific data and REALD & GI data for the project population):** CHA has implemented a comprehensive Case Management (CM) service across four programs: Screening, High Risk/Intensive Community Care Management (ICCM), Transitions of Care (TOC), and Short-Term Needs. These programs are designed to identify members with Special Health Care Needs (SHCN) through screenings and assessments. Members identified as having SHCN are flagged and provided with necessary resources and providers. Data capturing improvements have been made, particularly with REALD & SOGI data integration for monitoring disparities within the diabetic population of approximately 1,200 members, which is 4.6% of CHA's total membership.
17. **Describe whether last year's targets and benchmarks were met (if not, why):** The targets for 2023 included enhancing diabetes control among CHA members. However, the Diabetes HbA1c Poor Control OHA Incentive Metric indicated that 27% of members did not have optimal control. Additionally, efforts to provide oral evaluations were partially successful, with 20.1% of diabetic members receiving evaluations. The underachievement in some metrics was partly due to an oversight in diabetic assessments and a breakdown in the documentation process, which were addressed with new workflows and educational initiatives in early 2024.
18. **Lessons learned over the last year:** The integration of systematic data capture and reporting highlighted significant insights. The process adjustments in 2024, including the overhaul of documentation practices and the introduction of incentive programs, have begun showing potential improvements in member engagement and diabetes management. For instance, offering incentives like gift cards for completing diabetic care activities has positively influenced member compliance and engagement. Challenges remain in fully integrating various diabetes management efforts across the community, suggesting a

need for more coordinated efforts. The exploration of health disparities using REALD & SOGI data has started, but more focused actions are needed to address these effectively. These findings and actions align with CHA's broader strategic goals of improving health outcomes, reducing disparities, and enhancing member and community engagement in diabetes management. The insights gained and the corrective steps initiated are expected to steer the project towards better outcomes in the upcoming years.

CHA Case Management (CM) services are provided to members identified by risk, utilization, or referrals from various sources for CM interventions. CHA's Care Management Model includes four CM programs: Screening, High Risk/Intensive Community Care Management (ICCM), Transitions of Care (TOC), and Short-Term Needs. The CM department identifies members with Special Health Care Needs (SHCN) through screening and assessment. All new CHA members, and those referred to case management from any source, complete a Health Risk Assessment (HRA)/ICCM screen. Based on the screening results, members who identify as having SHCN are flagged in their case management charts. After screening, members are evaluated to ensure they have the appropriate resources and providers in place. If any service gaps are identified, the CM team collaborates with the member, external providers, Utilization Review, and Provider Network teams to facilitate service acquisition. For repetitive service gaps, the Provider Network team is notified to improve network adequacy. In cases of poor outcomes due to access issues or lack of provider availability, CM works with the member, authorizations department, and provider network to address barriers and increase service availability within the CHA network.

Screening and resource provision are requirements for all members, regardless of demographics or population characteristics. However, as CHA develops reporting on disease prevalence, the ability to identify and address disparities will become crucial in decision-making processes to improve health outcomes. Future reporting on conditions under Special Health Care Needs (SHCN) will include available REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data. This will enable the exploration of disparities within priority populations, with a focus on implementing actions to reduce these disparities and enhance health outcomes wherever possible.

Regrettably, in 2023, oversight in completing diabetic assessments and a breakdown in the documentation submission process resulted in the unavailability of REALD data. This issue was identified and addressed in 2024 through the implementation of a new workflow, educational materials, and training initiatives. A project overhaul was undertaken to rectify these shortcomings. While progress was made and CHA was able to generate data, the project's linkage to diabetes metrics led to it narrowly missing the metric target for 2023. Cascade Health Alliance (CHA) recognized that multiple diabetes-focused initiatives were underway, each impacting diabetes management holistically, but lacking integration. CHA assessed the scope of these initiatives and decided to consolidate efforts where possible. This alignment aims to enhance efficiency in resource utilization and improve overall outcomes.

Per the International Journal of Preventative Medicine 2021, the holistic care approach to managing diabetes includes psychosocial, psychological support, lifestyle changes, health education, herbal food and medicine, culture, yoga, and technology (Juanamasta, I Gede et al. "Holistic Care Management of Diabetes Mellitus: An Integrative Review." *International journal of preventive medicine* vol. 12 69. 25 Jun. 2021, doi:10.4103/ijpvm.IJPVM_402_20).

CHA employs several ongoing strategies to assist members in managing their diabetes, in addition to the previously mentioned initiatives. Recently, CHA has implemented a Diabetic Incentive Program where members can get a $25 gift card for completing diabetic care activities such as getting their A1c checked or an

Oral Evaluation with their PCD. Diabetic members in 2022 who did not get an A1c test were offered one of these gift cards in exchange for getting an A1c done in 2023. 75% of the selected members who took action and earned the incentive also reported being in good control showing a possible link between members trending towards a positive outcome and reducing their clinical engagement due to lack of a felt necessity. Reaching this population and encouraging them to engage with the healthcare system is a key point of CHA's diabetic management strategy.

Since the onset of the Public Health Emergency in 2020, diabetic supplies have been delivered directly to members. With the shift to delivery, CHA is exploring methods to supplement this education gap, such as including educational materials with diabetic supplies. CHA's case managers utilize PointClickCare to monitor hospitalizations systematically, ensuring consistent medical and social needs check-ins with members to support disease management and care coordination. Additionally, CHA piloted an opt-in text messaging program, the Diabetic Care Compliance Program, in collaboration with mPulse. This program educates and reminds participants about the importance of regular blood sugar self-checks, medication adherence, healthy dietary habits, foot care, exercise, and overall healthy lifestyle behaviors. Furthermore, CHA actively participates in the Healthy Klamath Expanded Network for Diabetes Management. This partnership aims to strengthen the rural healthcare network in Klamath County, focusing on improving diabetes-related outcomes. Initiatives include enhancing access to and utilization of diabetes prevention programs (DPP), launching culturally relevant DPP classes (including a Spanish-speaking class and referrals to Klamath Tribal Health's DPP), and leveraging the Community Information Exchange (CIE) platform, Healthy Klamath Connect (HKC), to coordinate resources effectively and address social needs, thereby reducing health disparities.

Providers and other community partners are also actively engaged in improving diabetes management. Most members manage their diabetes through their primary care providers (PCPs), with additional support from a locally available endocrinologist and a nurse practitioner specializing in diabetes care. PCPs refer newly diagnosed diabetes patients to locally provided educational programs to assist them with the transition.

Organizations such as Cascades East Family Medicine (CEFM), Klamath Health Partnership (KHP), Klamath Basin Behavioral Health (KBBH) have implemented various approaches to diabetes management, though the impact of these efforts remains unknown. Despite the collaborative efforts of CHA and numerous organizations in Klamath County, challenges in disease management and diabetes complications persist. This situation suggests that, despite frequent collaboration, efforts are only partially coordinated, leading to a perceived lack of education, support, and resources for members with diabetes. This perception will be further investigated throughout 2024 to identify and address the underlying causes.

Consumption of services and health outcome measures are critical in evaluating the success of diabetes management initiatives. They help identify key opportunities for interventions to improve overall health outcomes, particularly in lowering HbA1c levels.

In 2023, CHA reported that 27% (312 out of 1154 members) of adult members with diabetes had poor control of their diabetes, according to the Diabetes HbA1c Poor Control OHA Incentive Metric. CHA recognizes that high HbA1c levels can lead to multiple complications, worsening member health, and increasing emergency department (ED) utilization and costs. Additionally, 20.1% (243 out of 1209 members) of adult members with diabetes received an oral evaluation, as per the OHA Incentive Metric Oral Evaluation measure.

Among adult members with diabetes included in the Oral Evaluation measure denominator:

- 34.5% (417 out of 1209 members) received at least two HbA1c tests during 2023.
- 96.4% (1166 out of 1209 members) are assigned to a primary care provider (PCP).

- 93.5% (1130 out of 1209 members) are assigned to a primary care dentist (PCD).

The Centers for Disease Control and Prevention (CDC) recommends that patients with diabetes have an HbA1c test completed every three to six months, at least twice a year.

While individual activities and monitoring measures are detailed below for their outcomes, root causes, and insights, this year's project review also requires an analysis of the impact of REALD (Race, Ethnicity, Language, and Disability) and SOGI (Sexual Orientation and Gender Identity) data on decisions and project contexts. As the project focuses on CHA's diabetic population of approximately 1200 out of 26,000 members (4.6%), we aim to explore this population for any deviations that could indicate health equity challenges or biases.

In the overall CHA population, 16.7% of members self-identify as a minority race. In the diabetic population, this decreases slightly to 15.9%, but the deviation is not significant given the small populations being examined and the high variance possible in small groups. This close parallel is replicated even at individual race and ethnicity levels, with no single group exhibiting a higher prevalence of diabetes within the CHA population.

When evaluating HbA1c measurement outcomes, a similar pattern emerges. The CHA diabetic population's average HbA1c level is 7.8, with all racial groups falling within a 1-point range of that average after accounting for variance within the outliers.

In 2024, CHA will develop a plan to incorporate SOGI data to examine potential HbA1c disparities across the network, further ensuring that any health equity challenges are identified and addressed.

D. Brief narrative description

1. **Project population:** The Holistic Diabetes Management project specifically targets the diabetic population within CHA's community, which consists of approximately 1,500 members. This group includes individuals diagnosed with diabetes and pre-diabetes, focusing particularly on: Members with Poorly Controlled Diabetes: Those who have an A1c measure of 9 or greater. Members Without Recent HbA1c Tests: Individuals who have not had an A1c test recorded in 2023.
2. **Intervention (address each component attached):** The intervention involves several components designed to improve diabetes management through enhanced care coordination, resource utilization, and community engagement. Each component is addressed as follows: **A. Enhancement of System-Level Infrastructure - System Alignment**: Streamline processes to ensure that diabetes management efforts are well-coordinated within CHA and with external stakeholders like primary care providers and community partners. - **Stakeholder Engagement:** Engage CHA staff, members, provider partners, and community partners actively in the management process to ensure comprehensive support and effective resource allocation. **B. Care Coordination and Management - Resource Utilization:** Utilize existing resources efficiently to support diabetes management, including health and social services, while also working to provide any lacking but necessary resources. - **PDSA Cycles**: Implement multiple Plan-Do-Study-Act (PDSA) cycles with small cohorts to refine the diabetes management process, making it scalable and adaptable based on real-time feedback and outcomes. **C. Access to Services-Improving Access**: Ensure that members with diabetes have access to high-quality and appropriate services at the right time and place, focusing on reducing under-utilization of preventive care and treatment. **Tool Leveraging**: Use tools like PointClickCare, Transitions of Care processes, and Healthy Klamath Connect (HKC) to reduce ED visits and avoidable inpatient admissions by managing high HbA1c levels more effectively. **D. Targeted Interventions for Specific Member Groups - Guided Management for High-Risk Members**: Assist members with poorly controlled diabetes by guiding them to effective management resources. - **Outreach for Members Lacking Recent Tests**: Reach out to members who have not undergone recent HbA1c tests, encouraging timely testing to better manage their conditions. **E.**

Expansion of Data Collection and Analysis - Inclusion of REALD/SOGI Data: Expand data collection to include REALD and SOGI data for diabetic and pre-diabetic members, focusing on identifying and addressing disparities. - **Data-Driven Interventions**: Utilize expanded data to implement targeted interventions aimed at eliminating disparities and improving overall health outcomes. **F. Broader Application and Sustainability - Methodology Application to Other Diseases**: Explore the application of successful diabetes management methodologies to other chronic diseases within the community. - **Transition to Routine Practice**: Aim to make these improved practices a routine part of healthcare provision by the project's conclusion, ensuring long-term sustainability and effectiveness. By addressing these components, the Holistic Diabetes Management project aims to significantly improve health outcomes for members with diabetes, reduce health disparities, and establish a more efficient and effective approach to chronic disease management within the community.

By December 31, 2025, the Holistic Diabetes Management project aims to enhance existing internal and system-level infrastructure to foster alignment and active stakeholder engagement, establishing a holistic, patient-centered approach to diabetes management. This initiative will guide care coordination, treatment development, and care transitions to improve health outcomes and reduce health disparities, while lowering diabetes management costs and minimizing duplicative efforts. Stakeholders include CHA staff, members, provider partners, and community partners. The project will leverage current resources and impact areas such as care coordination, access to health and social services, adverse actionable events, and OHA incentive metrics. Utilizing multiple Plan-Do-Study-Act (PDSA) cycles with small cohorts, the project is designed to be scalable. CHA will ensure that members know how to utilize available resources and will make every effort to provide any valuable, yet unavailable, resources to members with diabetes.

This project aims to significantly impact all five key factors of realized access (availability, accessibility, accommodation, acceptability, and affordability). However, it will most directly influence availability. CHA will ensure that members with diabetes have access to high-quality and appropriate services (right care at the right time and place) using a patient-centered approach to reduce the under-utilization of preventive care and treatment. CHA will continue its close collaboration with primary care providers in Klamath County. Leveraging tools and resources such as PointClickCare, Transitions of Care processes, and Healthy Klamath Connect (HKC), CHA staff will work with members to reduce emergency department (ED) visits and avoidable inpatient admissions due to high HbA1c levels.

As CHA enhances its infrastructure, the initial focus will be on two specific member groups:

- **Members with Poorly Controlled Diabetes**: CHA Case Management staff will assist members with a diabetes diagnosis and a most recent 2023 A1c measure of 9 or greater. These members will be guided to resources to help manage their condition effectively.
- **Members Without Recent HbA1c Tests**: CHA Quality Management and/or Member Services staff will reach out to members with a diabetes diagnosis who have no recorded A1c measurements from 2023. These members will be encouraged to complete HbA1c tests in a timely manner.

These activities can be accomplished using existing CHA resources and will be conducted concurrently with ongoing infrastructure enhancements for the remainder of the project.

With around 1500 community members in this diabetic population, CHA currently has the capability to engage activities aimed at reaching every member equally. However, as CHA improves its REALD/SOGI data collection, the project will be expanded to include Race, Ethnicity, Language, and Disability (REALD) and Sexual Orientation and Gender Identity (SOGI) data for diabetic and pre-diabetic members, with an emphasis on identifying and eliminating disparities through targeted equitable interventions.

Additionally, CHA will explore applying this methodology to other chronic diseases. The target is to transition this approach from a transformational initiative to a routine practice as the project concludes.

Supporting Documents

Health Promotion and Prevention Policy and Procedure

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

Activity 1 description: Monitor the impact of Holistic Diabetes Management project on health outcomes, and health disparities among members with diabetes.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Diabetes HbA1c Poor Control OHA Incentive Metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 27% of adult members with diabetes poor control	25% of adult members with diabetes poor control	12/2024	25% of adult members with diabetes poor control	12/2024
Monitoring measure 1.2	Oral Evaluation for Adults with Diabetes OHA Incentive Metric			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2023 20.1% of adult members with diabetes who received oral evaluation	21.3% of adult members with diabetes received an oral evaluation	12/2024	21.3% of adult members with diabetes received an oral evaluation	12/2024

Activity 2 description: For members diagnosed with diabetes, employ a dual strategy: actively reach out to ensure members who have not had A1c tests receive them, and enhance case management for members with diabetes who are experiencing poor control.

☐ Short term or ☒ Long term

Monitoring measure 2.1	CHA Case Management outreach to members with diabetes in Poor Control.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
31.3% (65/208) of adult members with diabetes who have A1c's 9 or higher at the end of 2023 received CHA case management	40% of adult members with diabetes who have A1c's 9 or higher receive CHA case management	12/2024	40% of adult members with diabetes who have A1c's 9 or higher receive CHA case management	12/2024
Monitoring measure 2.2	Increase A1c screening for members with diabetes with No Recent A1c Test through Provider and/or CHA outreach to all members without an A1c test in			

	2023			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
563 of adult members with diabetes did not report an A1c test in 2023	50% (282) of adult members with diabetes who did not receive an A1c test in 2023 are tested	12/2024	50% (282) of adult members with diabetes who did not receive an A1c test in 2023 are tested	12/2024

Activity 3 description: Integrate REALD & SOGI data to diabetes dashboard focusing on minority populations.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Maintain strong HbA1c performance among minority populations.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
15.9% of diabetic population are minority groups with an average HbA1c of 7.8%.	Maintain a sub 9% HbA1c value for minority diabetic populations.	12/2024	Maintain a sub 9% HbA1c value for minority diabetic populations.	12/2024
Monitoring measure 3.2	Increase A1c screening for minority members with diabetes with No Recent A1c Test through Provider and/or CHA outreach to all members without an A1c test in 2023.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
97 minority adult members with diabetes did not report an A1c test in 2023.	50% (49) minority adult members with diabetes who did not receive an A1c test in 2023 are tested	12/2024	50% (49) minority adult members with diabetes who did not receive an A1c test in 2023 are tested	12/2024

Section 2: Supporting information (optional)

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

QUALITY MANAGEMENT COMMITTEE
CHARTER

I. CHARTER STATEMENT

The Quality Management Committee (QMC) is created and charged by Cascade Health Alliance Board of Directors for the purpose of engaging providers and subcontractors in the service area to provide analysis, assessment, and advisement on the overall quality of services provided by Cascade Health Alliance (CHA), CHA's providers, and subcontractors.

II. PURPOSE:

The purpose of the Quality Management Committee is to:

1. Provide review and oversight of Cascade Health Alliance's Quality Assessment and Performance Improvement (QAPI) and transformation programs, including the Transformation and Quality Strategy (TQS) and CHA's internal Quality Strategy and Work Plan.
2. Analyze data and metrics, including identification of patterns from a quality management or improvement perspective.
3. When opportunities to improve clinical outcomes are noted, the QMC will work with CHA's Chief Medical Officer (CMO) and Director of Quality Management to create strategies to address deficiencies and setting targets for ongoing performance improvement.
4. Review and provide oversight of Grievances related to quality of care concerns, including review of any adverse events impacting CHA members.
5. Provide oversight of performance improvement projects, including:
    a. Reviewing quarterly reports
    b. Recommending topics for new performance improvement projects
    c. Reviewing and approving new performance improvement projects
6. Review and approve CCO policies and procedures related to Quality Management, as needed.
7. Oversee provider credentialing, including the review and reporting of actions taken against providers.
8. Provide oversight of the CCO's Quality Improvement Plan effectiveness in conjunction with CHA'S Utilization Review Committee/Clinical Advisory Panel.
9. Review and approve relevant clinical practice guidelines.
10. Make recommendations to CHA Quality Management and Medical Affairs for action to improve performance and efficiency of CHA.

III. SCOPE:

The QMC will focus on engaging providers and clinics concerning quality management and performance improvement initiatives to ensure that CHA members are receiving high-quality care. QMC serves as an advisory panel to assist CHA in enhancing member experience and achieving the quintuple aim of improving population health, enhancing member experience, reducing costs, supporting workforce well-being and safety, and advancing health equity .

QUALITY MANAGEMENT COMMITTEE
CHARTER

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 monthly, no less than every two months.

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 staff 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 Revised: October 30, 2023
Date Approved: November 2, 2023

QMC Meeting – February 2, 2023
CHA Boardroom/ RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Stanton Smith, MD ; Hannah Hayes, PA; Aaron Davis, DMD; Jordan Hoese, MD; David Elliott; Jeff Dover, JD; Chanel Smith; Shelley Emary; Sherrie Ardolino; Tayo Akins

Absent : Michol Polson, PhD ; Michael Donarski

Motion to approve minutes from December 1, 2022

- **Motion – Nora**
- **Second – Hannah Hayes PA**
- **All approved**

Sanction Monitoring Activities Reviewed: Q4 + November 2022 – No new findings.

Reviewed Credentialing Files: December

- [redacted]
  - **Motion – Hannah Hayes PA**
  - **Second – Nora Foster QMHP-C**
  - **All Approved -6/1/23 had extended approval. Case was dismissed. Motion to move to a permanent approval through the end of the term ending 12/3/23**
- [redacted]
  - **Motion – Nora Foster QMHP-C**
  - **Second – Aaron Davis DMD**
  - **All approved**
- [redacted]
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**
- [redacted]
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**
- [redacted]
  - **Motion – Hannah Hayes PA**
  - **Second – Aaron Davis DMD**
  - **All Approved**
- [redacted]
  - **Motion – Nora Foster QMHP-C**
  - **Second – Hannah Hayes PA**
  - **All approved**

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)

Quality Measure Dashboards:

- CHA 2022 Status – Missing 2 of the Challenge pools- MLA and Child and Adolescent Well Care visit. Strategizing internally to work with Quality Metrics Workgroup to ensure future success. Currently meeting 11 of the 14 measures. Issues with Reliance data so IET measure is not reflecting current reporting for the measure. Passing all the EHR metrics. Based on current performance, CHA will earn 100% of the 2022 incentive metric pool.
- ATRIO 2022 Status – Will be getting updates for performance monthly. Trying to get practice level data and performance.

Compliance Monitoring Review:

- Jeff Dover presented the results of the 2022 EQR audit. CHA met 5 of the 8 elements for CMR Compliance. Goal is to meet all 8 elements. Improvement plan is being implemented for the partially met 3 measures.
- CHA exceeded the average statewide CCO EQR score.
- No strengths were identified for the QAPI standard. Need to revise aspects of it to meet the federal and state requirements but information was generalized so CHA is working through the specifics to turn the partially met measures into fully met.
- Develop a QAPI workplan for 2023 by March QMC meeting.
- LTSS – monitor mechanisms within the MOU.
- QMC – standardize a schedule to capture discussion and activities.
    - Not enough detail overseeing subcommittees.
- Need to demonstrate compliance by explaining quality assessment and performance improvement plans that entails improvement activities and proper oversight.

Credentialing Discussion:

- Foreign Graduates – Jeff Dover presented the challenge that with foreign dental graduates, CHA may not be unable to obtain primary source verification and sought committee guidance on how to proceed in these instances. Aaron Davis brought up the requirements for DMD licensing and Stanton Smith said primary source verification of the secondary schooling education from a foreign grad would've already been verified at some point.
- Jeff Dover also sought input regarding credentialing of providers that don't have BLS or ACLS certification and or hospital privileges.

Committee Membership Updates:

- Paul Stewart has retired and is no longer a member.
- David Cauble, CEO at Sky Lakes Medical Center, will be replacing him soon.

Other:

- Dr. Stanton Smith arrived at 7:40am.
- Dr. Jordan Hoese provided feedback via email.

Adjourned: 8:00AM

Respectfully Submitted:

Dr. David Shute	Sherrie Ardolino
CMO QMC Interim Chair	Quality Transformation Coordinator

Cascade Health Alliance, LLC

QMC Meeting – March 2, 2023 – 0703
RingCentral

Present: David Shute, MD (CMO); Nora Foster, QMHP-C; Stanton Smith, MD; Paul Stewart; Hannah Hayes, PA; Aaron Davis, DMD; Patricia Pahl; David Elliott; Jeff Dover, JD; Chanel Smith; Shelley Emary; Michael Donarski; Sherrie Ardolino; Jordan Hoese, MD, David Cauble

Absent:Tayo Akins, Michol Polson, PhD

Motion to approve minutes Feb 2, 2022
- **Motion – Nora Foster**
- **Second – Hannah Hayes PA**
- **All approved**

Reviewed Credentialing Files: February 2023
- [redacted]
  - Motion – Hannah Hayes PA
  - Second – Nora Foster QMHP-C
  - All Approved
- [redacted]
  - Motion- Hannah Hayes PA
  - Second Nora Foster, QMHP-C
  - All Approved
- [redacted]
  - Motion- Hannah Hayes PA
  - Second- Nora Foster, QMHP-C
  - All approved
- [redacted]
  - Motion- Hannah Hayes PA
  - Second Nora Foster, QMHP-C
  - All Approved
- [redacted]
  - Motion- Nora Foster, QMHP-C
  - Second Jordan
  - All Approved
- [redacted]
  - Motion- Nora Foster, QMHP-C
  - Second- Hannah Hayes PA
  - All Approved

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)

➢

Quality Measure Dashboards

- CHA
  - Concerns meeting two challenge pool measures. Can fully attest to MLA but data capturing members needing interpretive services was problematic because of developing processes throughout the year. Well care visits for adolescents experienced some barriers with recruiting which impacted our ability to meet target goals. IET SUD not sure where we are at with this since there were issues with Reliance temporarily, so we are still awaiting the data from that.
- Atrio
  - Goal is to start getting dashboards monthly to better align with our STARs measures and setting goals.

TQS QAPI

- EQR review and provide feedback for next meeting approval.
- Providing more regular feedback and updates from other committees (PNMC, URC etc) for input and decision-making process. Providing a clear oversight of activities.
- No questions about report, plan or committee role.
- Per David Shute, the committee does have input on quality and encouraged feedback from members.

Adjourned: 7:56AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

QMC Meeting – May 4, 2023 – 0703
RingCentral

Present: Nora Foster, QMHP-C; Hannah Hayes, PA; Aaron Davis, DMD; Jeff Dover, MD; Jordan Hoese, MD, Stanton Smith MD, David Shute, MD (CMO); David Elliott; Chanel Smith; Shelley Emary; Sherrie Ardolino; Tayo Akins

Absent: Michael Donarski; David Cauble

Motion to approve minutes March 2, 2022
- **Motion – Hannah**
- **Second – Nora**
- **All approved**

Reviewed Credentialing Files: March 2, 2023

[redacted]
- **Motion – Aaron Davis DMD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]
- **Motion – Aaron Davis DMD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]
- **Motion – Aaron Davis DMD**
- **Second – Jordan Hoese MD**
- **Vote: 3 Yes, 1 No – Approved**

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Hannah Hayes PA**
- **All approved**

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Hannah Hayes PA**
- **All approved**

[redacted]
- **Motion – Jordan Hoese MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]
- **Motion – Aaron Davis DMD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Aaron Davis DMD**
- **All approved**

CMO-Approved prior to Committee (3 years):

- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)

No new sanctions to report on

Quality Measure Dashboards

- Final update on 2022 performance with preliminary results pending final updates in June.
- Well-Child Visit wasn't passed due to electronic health record issues and claims.
- Member engagement for oral evals proved beneficial.
- Collected enough information to pass MLA.
- IET OHA target was updated, and CHA should be passing.
- No questions or comments from committee members.

TQS QAPI

- Reviewed the requirements of the plan.
  Motion to Approve- Hannah Hayes PA
  Second- Nora Foster QMHP-C
  All Approved

Compliance Committee Update

- HSAG Audit would like involvement from QMC.
- Provided oversight of what the committee does and oversees.
- Fraud, Waste and Abuse- needs oversight from CCO's and topic of discussion is our audit program per Jeff Dover.
  - Behavioral Health Providers are being audited to ensure proper documentation, seeing the patients, showing treatment, goals, and progress of our members. Purpose is to show more oversight and involvement to strengthen the chart auditing program.
  - Implementing a new chart reporting program to prove proper stewardship.
  - Committees input on full criminal background check for recredentialing and requirements/policies/procedures since it does have a financial impact.
    - OHA does not have a requirement on recheck per Shelly Emary's findings.
    - Renewal application does have an attestation regarding key background findings.
    - Joint Commission and NCQA also does not have background check requirements for recredentialing.
    - Point of process it is not in current policies and will be discussed with Ops regarding final decision before brought back to the committee.

Utilization Review Committee

- Review of purpose and intent to provide oversight of the committee.
- Discussed updates and changes to flex funds, benevolent funds, OHA guidelines, and brief overview of the URC

Additional Comments and Feedback;

- Stanton Smith MD had technical difficulties and did not arrive until 7:30am

Adjourned: 7:58AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

QMC Meeting – June 8, 2023 – 0703
RingCentral

Present: Jeff Dover, Chanel Smith, Aaron Davis DMD, Jordan Hoese DO, Hannah Hayes PA, Shelly Emary, David Elliott, David Shute MD, Nora Foster QMHP-C, Sherrie Ardolino

Absent: David Cauble, Stanton Smith MD, Malea Waldrup, Tayo Akins, Michael Donarski

Motion to approve minutes May 4, 2022
- **Motion – Hannah Hayes**
- **Second – Aaron Davis**
- **All approved**

Reviewed Credentialing Files: May 8, 2023
[redacted]
- **Motion – Hannah Hayes**
- **Second – Aaron Davis**
- **All approved**

[redacted]
- **Motion – Hannah Hayes**
- **Second – Aaron Davis**
- **All approved**

[redacted]
- **Motion – Nora Foster**
- **Second – Hannah Hayes**
- **All Approved**

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] 3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] 3yrs)

Credentialing and Sanctioning
Change policy to be background check at initial credentialing only and remove full background check from the recredentialing process. Subject was previously discussed at the last QMC meeting.
Motion- Aaron Davis DMD
Second- Nora Foster
All Approved

Quality Measure Dashboards
Discussed May 2023's dashboard for the measures. EHR measure is lacking data from 3 of the 5 clinics.

TQS QAPI
Reviewed the TQS components, requirements and how it applies to the 8 projects.

Adjourned: 7:56AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

QMC Meeting – August 3, 2023 – 0703
RingCentral

Present: Jeff Dover, Chanel Smith, Aaron Davis DMD, Shelly Emary, David Shute MD, Nora Foster QMHP-C, Sherrie Ardolino

Absent: David Cauble, Stanton Smith MD, Malea Waldrup, Tayo Akins, Michael Donarski, **Jordan Hoese DO, Hannah Hayes PA,**

Did not have a quorum. Agenda items were not discussed or voted on.

Cascade Health Alliance, LLC

QMC Meeting – September 6, 2023
RingCentral

Present: Hannah Hayes PA, Art Belsky DMD, Stewart Decker MD, Jill Fay MD, Nora Foster QMHP-C, David Cauble, Stanton Smith MD, Sherrie Ardolino, Malea Waldrup, Jeff Dover, Chanel Smith, Shelly Emary, David Elliott, David Shute MD, Pedro Bernal

Absent: Tayo Akins, Michael Donarski

Motion to approve minutes June 8, 2023
- **Motion – Nora Foster QMHP-C**
- **Second – Stanton Smith MD**
- **All approved**

Reviewed Credentialing Files:

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Jill Fay MD**
- **All approved**

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Art Belsky DDS**
- **All approved**

[redacted]
- **Motion – Stewart Decker MD**
- **Second – Art Belsky DDS**
- **All Approved**

[redacted]
- **Motion – Hannah Hayes**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]
- **Motion – Hannah Hayes PA**
- **Second – Nora Foster QMHP-C**
- **All Approved**

[redacted]
- **Motion –Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]
- **Motion –Nora Foster QMHP-C**
- **Second – Art Belsky DDS**
- **All Approved**

[redacted]
- **Motion – Stewart Decker MD**
- **Second – Art Belsky DDS**
- **All Approved**

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] 3yrs)
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- (I) [redacted] (3yrs)
- (I) [redacted] 3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)

Sanction Monitoring
No new findings per Shelley Emary. SE briefly explained what OIG (Office of Inspector General) and brief explanation of monitoring process for the new members of QMC.

Quality Measure Dashboards
Chanel Smith provided update on Metrics Dashboards. On track to pass incentive pool measures. Unable to provide data on IET measures due to technical issues with Reliance. Oral Evaluation data unavailable currently but interventions are in place. Meaningful Language Access measure is not listed in the metrics provided but CHA is on track to meet this measure. KHP data is not reflected in the denominator numbers.

PNMC/URC Updates
David Shute MD reviewed the committee's roles and what is entailed. DS addressed capacity, assigning members and challenges.

Member Inactivity Monitoring
Drivers of current environment with members not seeing their primary care provider was discussed and CHA processes of assigning members. Proposed targeted outreach for members who have not seen their primary care provider or who are well.

Adjourned: 8:04AM

Respectfully Submitted:

_____ _____

_____ _____

Dr. David Shute, CMO QMC Interim Chair

Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

CCC Quality Management Committee
Thursday, October 5, 2023
7:00am – 8:00am
Cascade Comprehensive Care Boardroom
Microsoft Teams Meeting ID: 259 626 194 690 Participant Passcode: FXW74F
Call In (audio only) 1 (332) 249-0724
Conference ID: 703 402 229#

Present: Jill Fay MD, Art Belsky DDS, Stewart Decker MD, Nora Foster QMHP-C, Stanton Smith MD, David Shute MD, Jeff Dover, Shelley Emary, Chanel Smith

Absent: David Cauble

Motion to approve minutes September 6, 2023

- **Motion – Stewart Decker MD**
- **Second – Jill Fay MD**
- **All approved**

Reviewed Credentialing Files:

[redacted]

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All Approved**

[redacted]

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Jill Fay MD**
- **All Approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Art Belsky DDS**
- **All approved for 1 year**

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
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- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)

Sanction Monitoring
No findings and nothing to report. Shelly Emary reviewed 311 files as of October 1, 2023. Jill Fay inquired as to if the 311 files pertaining to the number of credentialed providers on the plan and SE confirmed that it was.

Credentialing Discussion
DEA is changing processes and offering a downloadable list. Jeff Dover and Shelly Emary are working on getting access. Certifications are being verified and once JD and SE have access, then they will reverify. No questions or concerns from the committee.

Quality Measure Dashboards
IET Initiation and IET Engagement is being tracked separately at this time, but the metric is passing. Art Belsky DDS recommends oral evals for diabetic patients who have dentures on a yearly basis. Chanel Smith proposed the idea of dental provider education on patients who have dentures to assist with meeting the metric. AB agreed with CS proposal and reaffirmed the importance of it.

Review Clinical Guidelines
P&T committee reviews ADA updates for formulary changes and Stewart Decker proposed information being shared by P&T directly to the clinics to be informed of the changes. DS stated CHA can provide this information directly. Jill Fay will be added to CareTalk Newsletter which contains updated information. Provider contacts from credentialing files were recommended to be used for distributing CareTalk Newsletter and updates and changes such as clinical guidelines. Art Belsky recommends a weekend training course for dental providers and their staff for CDC guidelines.

- **Motion- Stewart**
- **Second- Art Belsky**
- **All Approved**

Review QMC Charter
Will be moved to November QMC meeting**.**

Other:
Peer reference process will be added to next month's agenda for discussion.

Adjourned: 8:04AM

Respectfully Submitted:

_____	_____
Dr. David Shute, CMO QMC Interim Chair	Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

CCC Quality Management Committee
Thursday, November 2, 2023
7:00am – 8:00am
Cascade Comprehensive Care Boardroom
Microsoft Teams Meeting ID: 259 626 194 690 Participant Passcode: FXW74F
Call In (audio only) 1 (332) 249-0724
Conference ID: 703 402 229#

Present: Nora Foster QMHP-C, Stewart Decker MD, Jill Fay MD, Stanton Smith MD, David Cauble, Shelley Emary, Jeff Dover, David Schute MD, David Elliott, Chanel Smith, Sherrie Ardolino, Pedro Bernal

Absent: Art Belsky DMD

Motion to approve minutes October 5, 2023

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

Reviewed Credentialing Files:

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All Approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All Approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion- Nora Foster**
- **Second- Stewart Decker**
- **All approved for 1 year**

CMO-Approved prior to Committee (3 years):

- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)

Sanction Monitoring
Reporting for Q3 313 providers, no new findings to report.

Credentialing Discussion- Peer Review Discussion
Jeff Dover proposed to change policy of third reference to a waiting period of 30-45 days to speed up the credentialing process for administrative approval. Lack of third reference holds up the application process and waiting for the next committee meeting. Applications are often held until near expiration waiting for the third reference. Allow for administrative approval for applications that have received 2 of 3 referrals after 30 days and 3 attempts to obtain if the two referrals are positive then it is considered a clean referral and can obtain administrative approval.
Motion to approve: Stewart Decker MD
Second- Nora Foster
All approved for the revise process of the credentialing process for peer reviews.

Quality Measure Dashboards
There have been challenges with well-child visits and access issues. Trending behind in immunizations which could be related to a delay in collecting data from ALERT. Doing well with Post Partum. Over 40% at IET initiations and 22% on engagement with IET. At benchmark for preventative dental. Chanel Smith spoke briefly about KDK's role in filling gaps. Working with clinics and EHR metrics. Clinics are working on their reports and how information is captured. MLA measure is in hybrid reporting attestation period and quarterly reports are being sent out to clinics. Nora Foster feels behavioral health can help in aspects of metrics. Discussed capturing structure data of information and potential options for behavioral health being more involved with the metrics.

Review QMC Charter
Scope: updating from triple aim to quintuple aim.
Meetings: Cadence in meetings has changed to monthly, with no less than every 2 months.
Minutes: Made changes to the role taking notes.
Motion to Approve: Nora Foster QMHP-C
Second: Stewart Decker MD
All Approved

Other:
Next month: review Quality Policies

Adjourned: 8:04AM

Respectfully Submitted:

_____	_____
Dr. David Shute, CMO QMC Interim Chair	Sherrie Ardolino, Quality Transformation Coordinator

Cascade Health Alliance, LLC

CCC Quality Management Committee
Thursday, December 7, 2023
7:00am – 8:00am
Cascade Comprehensive Care Boardroom
Microsoft Teams Meeting ID: 259 626 194 690 Participant Passcode: FXW74F
Call In (audio only) 1 (332) 249-0724
Conference ID: 703 402 229#

Present: Nora Foster QMHP-C, Stewart Decker MD, Jill Fay MD, Stanton Smith MD, David Cauble, Art Belsky DMD, Shelley Emary, Jeff Dover, David Schute MD, David Elliott, Chanel Smith, Pedro Bernal.

Absent: Sherrie Ardolino

Motion to approve minutes November 2, 2023

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved – (Art Belsky DMD abstained for not being present at the time for vote)**

Sanction Monitoring:
No new findings to report per Shelley Emary.

Reviewed Credentialing Files:

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]

- **Motion – Stanton Smith MD**
- **Second – Stewart Decker MD**
- **All Approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Nora Foster QMHP-C**
- **All approved**

[redacted]

- **Motion – Art Belsky DMD**
- **Second – Jill Fay MD**
- **All Approved**

[redacted]

- **Motion – Jill Fay MD**
- **Second – Stewart Decker MD**
- **All approved**

[redacted]

- **Motion – Stewart Decker MD**
- **Second – Art Belsky DMD**
- **All approved**

[redacted]
- **Motion – Stewart Decker MD**
- **Second – Art Belsky DMD**
- **All approved**

[redacted]
- **Motion – Nora Foster QMHP-C**
- **Second – Stewart Decker MD**
- **All approved**
- **(1 year provision. Art Belsky DMD would like to request a clear discussion be had with provider about the decision)**

CMO-Approved prior to Committee (3 years):
(Table discussion)

- (I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- I) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (I) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)
- (R) [redacted] (3yrs)

Credentialing Discussion:
Annual Credentialing Policy and Procedure reviewed. Minor changes discussed.
Motion – Stewart Decker MD
Second – Nora Foster QMHP-C
All approved

Quality Measure Dashboards:
For the committee's review.

QAPI Discussion:
Annual QAPI Policy and Procedure reviewed. Minor changes discussed.
Motion – Nora Foster QMHP-C
Second – Jill Fay MD
All approved

Other:
Follow-up: Re-Credentialing process.

Adjourned: 8:02AM

Respectfully Submitted:

Dr. David Shute, CMO QMC Interim Chair	Pedro Bernal, Quality Project Manger

2023 CLAIMS METRICS - CASCADE HEALTH ALLIANCE

Cascade Health Alliance

3/28/2024
Pedro Bernal

Max Service Date: 12/31/2023 **Max Recevied Date:** 2/29/2024 **Avg Days:** 34

DISCLAIMER: 2023 measure spec updates/validation continues. 2023 targets calculated by CHA and will be updated once OHA produces final 2023 reporting.

Well-Child Visit

66.3%

Target: 57.1%
Benchmark: 68.6%
Num/Denom: 1,246/1,880
Actionable: 0
Gap: Meeting

Childhood Immz

58.3%

Target: 67.9%
Benchmark: 67.9%
Num/Denom: 264/453
Actionable: 0
Gap: 44

Adolescent Immz

37.0%

Target: 36.9%
Benchmark: 36.9%
Num/Denom: 163/441
Actionable: 0
Gap: Meeting

Postpartum Care

88.9%

Target: 84.2%
Benchmark: 84.2%
Num/Denom: 263/296
Actionable: 0
Gap: Meeting

IET Initiation

2023 data is not available yet

Target: 43.3%
Benchmark: 43.3%
Num/Denom:
Gap:

IET Engagement

Target: 15.0%
Benchmark: 16.3%
Num/Denom:
Gap:

Preventive Dental 1-5

58.8%

Target: 47.2%
Benchmark: 47.2%
Num/Denom: 1,481/2,518
Actionable: 0
Gap: Meeting

Preventive Dental 6-14

64.5%

Target: 54.8%
Benchmark: 54.8%
Num/Denom: 2,974/4,611
Actionable: 0
Gap: Meeting

Oral Evaluation

20.9%

Target: 21.5%
Benchmark: 26.4%
Num/Denom: 228/1,089
Actionable: 0
Gap: 7

DHS Assessments

83.3%

Target: 90.0%
Benchmark: 90.0%
Num/Denom: 50/60
Actionable: 0
Gap: 4

DHS Physical Health

95.0%

Num/Denom: 57/60
Actionable: 0

1/3 of Assessments

DHS Dental Health

86.8%

Num/Denom: 46/53
Actionable: 0

1/3 of Assessments

DHS Mental Health

100.0%

Num/Denom: 42/42
Actionable: 0

1/3 of Assessments

Data Sources:
Plexis, ALERT IIS, Reliance, PRM Analytics, and Essette
Allow for 1-4 months claims lag

Challenge Pool Measures:
Well-Child, Adolescent Immz, Postpartum Care, and Preventive Dental (1-5 and 6-14)

Confidentiality Statement: This report along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

QUALITY MANAGEMENT DATA USE POLICY AND PROCEDURE

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

CONTENTS

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

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 Business Intelligence (BI) department according to OHA metric specifications and any additional referenced metrics specifications (i.e. CMS, HEDIS, etc.)

Confidentiality Statement
This QM Data Use Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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 utilizing the Minnesota Method.

3.1.2.1 New performance measures introduced by the MSC undergo testing and validation by the BI department, and 3rd party vendor, Reliance eHealth.

3.1.3 Reliance eHealth Collaborative and PRM Analytics are used as secondary validation and reconciliation sources for internally generated reports.

3.1.3.1 The BI department maintains the shared data between Cascade Health Alliance (CHA) and Reliance eHealth.

3.1.3.2 The BI department maintains the shared data between CHA and PRM Analytics.

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 outputs 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 and the Director of Quality Management, 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 BI using the Report Request form and process.

Confidentiality Statement
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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 Milliman Care Coordinator; 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 Plexis Quantum Choice 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 QM Department 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 BI staff compile data reports monthly, which are shared within the department and to the 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 by 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.

Confidentiality Statement
This QM Data Use Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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 and reports are sent to Reliance and PRM Analytics as well as data reports received from Reliance and Milliman 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	01/02/2021
Approval Dates	01/23/2021

10 APPENDIX

Quality Metrics Dashboard Process DP09005.01

Confidentiality Statement
This QM Data Use Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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 (QM) department.

3 PROCESS

3.1 Data Analysts in the Business Intelligence (BI) Department run the internal reports for metric performance and refresh the dashboard built in Tableau.

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

3.3 The CMO, QM Director, and BI Manager 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 Workgroup 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.

Confidentiality Statement
This Quality Metrics Dashboard Process along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

Cascade Health Alliance, LLC

cascade comprehensive care, inc.

HEALTH PROMOTION AND PREVENTION

POLICY AND PROCEDURE

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

CONTENTS

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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 Cascade Health Alliance (CHA) 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 (QM) Department will establish an annual plan for Health Promotion and Prevention activities as part of its annual strategic planning process.

5 RESPONSIBILITIES

Confidentiality Statement
This Health Promotion and Prevention Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

Compliance, Monitoring and Review

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

5.2 CHA's QM 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 QM 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 Quality Assurance and Performance Improvement Policy PP09007

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

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

7.4 Health Insurance Portability and Accountability Act (HIPAA)

7.5 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	09/02/2021
Approval Dates	09/02/2021

10 Appendices

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

Confidentiality Statement
This Health Promotion and Prevention Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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

Confidentiality Statement
This Health Promotion and Prevention Appendix 1 along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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

Confidentiality Statement
This Health Promotion and Prevention Appendix 1 along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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

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- 3.2.2 At an initial prenatal exam

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TQS Section 3.A REQUIRED

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

Confidentiality Statement
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TQS Section 3.A REQUIRED

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.

TQS Section 3.A REQUIRED

- 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.

TQS Section 3.A REQUIRED

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.

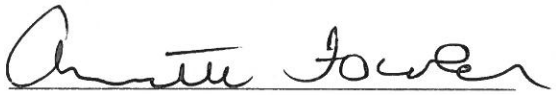
IX. CHARTER REVIEW

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

TQS Section 3.A REQUIRED

Cascade Comprehensive Care, Inc.
Compliance Committee Meeting – CCC Boardroom/Ring Central
Tuesday, March 28, 2023 – 7 AM

Present: Grant Kennon, Dr. Graham and Dr. Mirande

CCC: Tayo Akins (CEO), Michael Donarski (COO), Jeff Dover (Compliance Officer), Amanda Hascall (FWA Auditor), and Faith Lee (Compliance Specialist)

Absent:

Meeting called to order 7:04 AM.

Motion to approve Compliance Committee Meeting minutes from December 16, 2022. (**Michael**)
Motion seconded. (Jeff)
Motion passes unanimously.

1. OHA Deliverables– **Discussion only, no motions**
    a. 2023 to Date
    b. 2023 EQR Audit
    c. Three-year cycle
2. Grievance and Appeals– **Discussion only, no motions**
    a. 2022 Q4 Data
3. Fraud Waste and Abuse– **Approval on the Polices and Procedures Approval- Tracy, Second- Grant**
    a. Current Open Investigations

        Discussion only, no motions on open investigations

Adjournment 7:26 AM.

Next meeting: June 28, 2022

Respectfully Submitted,

_____ _____

Grant Kennon, Compliance Committee Chair Jeff Dover, Compliance Officer

Cascade Comprehensive Care, Inc.
Compliance Committee Meeting – CCC Boardroom/Ring Central
Tuesday, March 28, 2023 – 7 AM

Present: Grant Kennon and Dr. Mirande

CCC: Tayo Akins (CEO), Michael Donarski (COO), Jeff Dover (Compliance Officer), Amanda Hascall (FWA Auditor), and Faith Lee (Compliance Specialist)

Absent: Dr. Graham

Meeting called to order 7:02 AM.

Motion to approve Compliance Committee Meeting minutes from December 16, 2022.
Motion seconded.
Motion passes unanimously.

1. OHA Deliverables– **Discussion only, no motions**
    a. 2023 to Date
    b. 2023 EQR Audit
    c. Three-year cycle
2. Grievance and Appeals– **Discussion only, no motions**
    a. 2022 Q4 Data
3. Fraud Waste and Abuse– **Discussion only, no motions**
    a. Current Open Investigations

        Discussion only, no motions on open investigations

Adjournment 7:25 AM.

Next meeting: August 15, 2023 In person

Respectfully Submitted,

_____ _____

Grant Kennon, Compliance Committee Chair Jeff Dover, Compliance Officer

Cascade Comprehensive Care, Inc.
Compliance Committee Meeting – CCC Boardroom/Ring Central
Tuesday, August 15, 2023 – 7 AM

Present: Grant Kennon, Dr. Graham, and Dr. Mirande

CCC: Tayo Akins (CEO), Michael Donarski (COO), Jeff Dover (Compliance Officer), and Faith Lee (Compliance Specialist), Brittany Pennington (Compliance Training and Policy Analyst), Amanda Hascall (FWA Auditor)

Absent: N/A

Meeting called to order 7:02 AM.

Motion to approve Compliance Committee Meeting minutes from August 15, 2023.
Motion seconded.
Motion passes unanimously.

1. OHA Deliverables– **Discussion only, no motions**
    a. 2023 EQR Audit Preliminary Findings
    b. Three-year cycle
2. Grievance and Appeals– **Discussion only, no motions**
    a. 2023 Q3 Data
3. Fraud Waste and Abuse– **Discussion only, no motions**
    a. Annual Reporting
    b. Audit Update

        Discussion only, no motions on open investigations
4. Annual Policy Review– **Motion to approve. Motion seconded. Motion passes unanimously.**
    a. Compliance Policies for 2024
5. 2024 Meeting Schedule- **Discussion only, no motions**

Adjournment 7:50 AM.

Next meeting: March 26, 2023

Respectfully Submitted,

_____ _____

Grant Kennon, Compliance Committee Chair

Jeff Dover, Compliance Officer

Provider Network Management Committee Charter

I. CHARTER STATEMENT

The Provider Network Management Committee (PMNC) is created to perform analysis, assessment, and identify areas of opportunity for provider network adequacy and capacity to serve the Cascade Health Alliance (CHA) membership. The provider network adequacy data reporting is integrated to encompass the following focus areas:

- Member Demographics
- Primary Care Physical (PCP) and Primary Care Dental (PCD) Capacity
- Primary Care Physical and Dental Provider Performance Dashboards
- Specialty Providers by Category and Network Status
- Disease Prevalence
- Grievance and Appeals Data
- Language and Interpretive Services
- Secret Shopper Surveys for
    - PCP/PCD
    - Specialty Providers; and
    - Behavioral Health

II. PURPOSE

The purpose of the Committee is to:

1. Assess network capacity, access, and adequacy, including but not limited to, corrective action plans, policies, guidelines, and analytics to assess CHA provider network adequacy and capacity.
2. Develop and monitor key performance indicators and establish goals/thresholds through reporting and dashboards. Identify and discuss areas requiring action plans to address adequacy and capacity concerns and/or barriers.
3. Make recommendations and actions to the committee on the importance and priority of addressing provider network adequacy, access and capacity concerns.
4. Develop and support the establishment of procedures, processes, and workflows to assist CHA and CCC in executing and implementing provider network strategies.
5. Ensure compliance with rules, regulations, and guidelines under CCO agreements, CFRs, OAR's, and other applicable state and federal requirements.

III. SCOPE

- The PNMC focuses on development of regional PNM monitoring tools to support compliance with rules, laws, and the Oregon Health Authority contract, including without limitation any 3rd party audits, findings and recommendations.
- The PNMC Provides requested information and supports development of the provider network to ensure all covered services are adequately and timely provided.

- Identifies and monitors provider clinics and facilities for gaps in service delivery or potential barriers to care.
- Supports development and implementation of a provider network strategic plan.
- Looks for opportunities and recommends strategies to establish uniformity in contract language revisions and updates as recommended by OHA and/or audit findings.
- Delivers provider clinic education, training, and material as required.

IV. RESPONSIBILITIES

Responsibilities of PNMC include, but are not limited to:

- Monitoring and reporting provider network access, adequacy and capacity.
- Offering recommendations and development for strategies and action plans to ensure appropriate access is maintained for membership of PCPs, PCDs, behavioral health and specialty practitioners.
- Developing of reports to monitor progress and impacts of changes made or needed within the network.
- Identifying and reviewing provider panel issues brought forward by members, stakeholders, CCC employees, Community Advisory Council, and providers.
- Identifying annual provider training topics.

V. MEETINGS

The PNMC will meet monthly, unless canceled due to unforeseen issues. The PNMC will meet no less than once per quarter. Additional meetings may be called by the Chairperson to establish greater meeting frequency necessary to conduct the business of the Committee and to address critical issues in a timely manner.

The PNMC Chairperson or designee will set meeting dates, times, locations, agendas and prepare other meeting materials and documents as necessary.

VI. MEMBERSHIP

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

Chief Financial Officer
Chief Operations Officer
Chief Medical Officer
Provider Network Manager
Director of Member Experience
Director of Clinical Operations
Director of Claims
Director of Quality Management & Health Equity
Compliance Officer
Compliance Analyst
Grievance and Appeals Analyst; and

Credentialing Specialist

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 the business.

Role of a PNMC Member

It is intended that the PNMC leverage the experience, expertise, and insight of key individuals across a wide spectrum of functions within the organization. Individual 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 issues or topics for discussion prior to meetings for inclusion in meeting agenda or raise issues during meetings.
- Review and be accountable for their role in the group's efforts and attend meetings consistently or assign a Chairperson approved delegate (if needed).
- Participate in framing issues and be familiar with how the activities of the Committee are relevant to all lines of business.

VII. MEETING STANDARDS

The Chairperson of the PNMC 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.

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 prior to the subsequent meeting. The final meeting minutes shall be provided at the next regularly scheduled meeting of the Committee for approval.

VIII. SUB COMMITTIES / WORK GROUPS

The PNMC 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 PNMC shall receive updates from and shall oversee any sub-Committees and work groups that are created and delegated PNMC activities.

IX. CHARTER REVIEW

The PNMC charter shall be reviewed at least annually. Material revisions to the Charter shall be approved by executive management.

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

April 27, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow Highlighted = Member Absent	
1.	Open Meeting; Approve Previous Month's Minutes. David moves and Jeff Second.	Biagio
2.	Network Access concerns and updates. Discussed current access issues with Oral pediatric surgeons and working with Oregon Pediatric Dentistry Clinic via LOA's to avoid any bottle neck of CCO-F members. Reviewed quarterly updated slides that included data captured from Secret Shopper surveys. Discussed creating and adding CHA standards to eventual dashboards to further monitor clinics meeting said standards.	Biagio
3.	Quality Metrics performance, access concerns and updates. Discuss PCPCH weighted performance as it relates to unassigned members. Because of increase in membership weighted score is decreasing. Chanel also reviewed	Chanel

	updated Q1 language interpretive services slide. CHA seeing a lot more data from providers. CHA passed MLA measures and met the 80% OHA guideline benchmark. Dat being collected is more refined, however, working with clinics to have better updates on charts and further refining the data.	
4.	Medical updates, concerns, and access point issues. David: growing problems with provider performance with authorization. Creating operational issues because of missing information, incorrect information etc. Challenges with DME i.e. [redacted]. SLMC contracts with Pacific Medical and Synergy as a possible replacement or added DME supplier.	David
5.	Appeals & Grievances updates and concerns. Kim, Q1 G&A data coming in May meeting. Reviewed and discussed non-compliance of subcontracted/delegated entities of grievances captured and notice of same. Reviewed a sample from [redacted] and [redacted] to be put on corrective action plan (CAP) to monitor and resolve. Kim to initiate CAP from Q1 through Q4 2023 to monitor for correction. Both entities will have to report monthly through 2023 with CHA to oversee and ensure compliance. Jeff added that Compliance is looking to do	Kim

	more in person audit to help educate clinics on what is needed and help avoid future compliance issues.	
6.	Case Management gaps, concerns, and updates. Arthur not present.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff ramping up provider auditing. Credentialing delegated agreements compliance with contractual obligations. EQR submitted last week. Working at better efficiencies when it comes to auditing and administrative challenges for provider clinics.	Jeff
8.	Members Services, access issues, concerns, and updates. No new updates, current major focus is on re-determination efforts as this comes into focus for 2023-2024. Educating members on same.	Tammie
9.	Adjourn	
	NEXT MEETING **MAY 25, 3:30-4:30 PM**	

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

August 24, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Highlighted members absent.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Approved as amended.	Biagio
2.	Network Access updates and concerns. Biagio gave updates. Michael Sheet retiring. Michael D. Court Street responded and Dr. Haddad willing to contract for extractions for our members.	Biagio
3.	Quality Metrics performance, access concerns and updates. Michael for Chanel, Provider Engagement plan with Sherrie. Need to engage PNM on this.	Chanel- - ABSENT
4.	Medical updates, concerns, and access point issues. Sleep and Pulmonary wait time is up to year, David allowing reviewers to approve out of town PA's to help.	David

	Discussed D. Elliot's presentation last month. This is an under-utilization issue. David S. willing to come back to committee with a proposal on how to solve this.	
5.	Appeals & Grievances updates and concerns.	Kim ABSENT
6.	Case Management, gaps, concerns, and updates.	Arthur ABSENT
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Making good progress with SLMC on credentialing. Moving towards educating them to help expedite credentialing that is more efficient and complete. Concerns with OHA network adequacy changes. How they intend to monitor and police these changes.	Jeff
8.	Members Services, access issues, concerns, and updates.	Tammie ABSENT
9.	Adjourn	

NEXT MEETING

SEPTEMBER 29, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

January 26, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera; Dawna Oksen; David Shute; Leanne Rose; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji M	
1.	Open Meeting; Approve Previous Month's Minutes Michael noticed the error in Attendees that needs to be changed the attendees who actually attended and not those who were invited. Chanel to send PNM new CHA minutes template to implement in February and moving forward.	Biagio
2.	Network Access PNM gave access update; long discussion on BP cuffs, vendors and required educational piece that must be made in person. Medline as an option for immediate backlog solution. PNM Updated committee on new BH provider and possibility of a new Mobile dental clinic.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel commented that additional claims still incoming that will affect some of the performance metrics and at	Chanel

	least one (DHS Dental Assessment) will change from red to green to meet the annual target. Depending on the number of claims, Oral Assessment may also hit the target at well.	
4.	Medical updates, concerns, and access point issues. BP Cuff issue covered, no other concerns.	David
5.	Appeals & Grievances updates. Kim is working on Q4 update, will have that data to share and present in February meeting.	Kim
6.	Case Management gaps, concerns, and updates. BP Cuff concerns already discussed, otherwise no other updates.	Arthur
7.	Compliance and Provider related issues or updates. Credentialing and Contracting issues, concerns, and updates. Jeff & Faith PTO. Shelley commented on Credentialing items taking so long from providers and getting incomplete applications.	Jeff
8.	Members Services update.	Michael

Contracts and Compliance Meeting discussed network and adequacy standards are changing for 2024 contract. We would be considered a rural setting where Medford/Bend considered closest Urban area. Meeting set for February 2023.
9. Adjourn
NEXT MEETING **FEBRUARY 23, 3:30-4:30 PM**

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

July 27, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow = Absent	
1.	Open Meeting; Review and approve previous month Meeting Minutes. July slide deck update: errors found after they were sent, corrected revised deck will be sent to the committee. Jeff D. Moved to enter June minutes; David S. 2nd.	Biagio
2.	Network Access concerns and updates. PNM gave access update. No new movement on adding Capitol Dental; PNM updated PNMC on staffing improvement at Timber Kids; No significant changes in BH; PCP's extremely busy, otherwise no changes.	Biagio
3.	Quality Metrics performance, access concerns and updates. Chanel S. not present for July.	Chanel
4.	Medical updates, concerns, and access point issues.	David

	David S., no access concerns. Are we going to discuss David E. Presentation. This is an access concern. David mentioned to be approached to join a collaborative to recruit Providers. Early stages of development and want to have CHA as a part of it.	
5.	Appeals & Grievances updates and concerns. Kim W., no new updates.	Kim
6.	Case Management gaps, concerns, and updates. Arthur P., [redacted], additional feedback from Kim regarding [redacted]s.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff D. briefly discussed data breach at Capitol dental, low impact to CHA members. Jeff D. briefly discussed data breach at Capitol dental, low impact to CHA members. Credentialing delegation agreements terminated. EQR audit went well, waiting for comments.	Jeff
8.	Members Services, access issues, concerns, and updates. Received negative feedback for lack of provider choice, approximately 10 to 15 members. Same with wait times on clinics. These are being sent to Kim for grievances.	Tammie

9. Adjourn

NEXT MEETING

AUGUST 24, 3:30-4:30 PM

PRIOR TO THIS AGENDA: **David Elliot** guest presenter on PCP Provider Inactivity. Provided data on Member that are either inactive for a period of time or never had an initial consultation being dropped from their provider as a result. Up to 35% of capitation not being utilized. Resulting unassigned members being seen at other PCP clinics. David reviewed raw data, by member and clinic population as compared to capitation PM/PM. Brief historical review of where members have been seen by year and clinic for services.

Continued discussion without David Elliot: David S. concerned this is an access issue. Suggested a contractual change. Another area of concern is the members that are in our Quality metrics pool and issues with the incentive metric areas. David S. would like to start to discuss interventions and to discuss this further. Clarification is needed as our clinics are reporting that they do not drop CHA members under for inactivity. Tammie S. will start keeping track of members and ID numbers for these members for further review. Kim will review grievances as well to track, valid and bring to committee.

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

June 22, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow= Absent Member	
1.	Open Meeting; Review and approve previous May Meeting Minutes. Move by: Jeff Second by: Arthur	Biagio
2.	Network Access concerns and updates.	Biagio
3.	Quality Metrics & Health Equity: performance, access concerns and updates. No metric issues. The MLA interpreter training, building up that network with OHA approved interpreters. Work on adding trainings with our providers to certify more. Language line actively recruiting interpreters. KOD PCP's leaving. Focus on replacements.	Chanel
4.	Medical updates, concerns, and access point issues. David Shute not present.	David
5.	Appeals & Grievances updates and concerns.	Kim

	No Q1 updates, dashboard issues. Will have next month. No other updates.	
6.	Case Management gaps, concerns, and updates. Member can't get a continuous glucose monitor, Byram saying we are out of network. That is not the case. Escalating to resolve. SLMC is the only home health provider in Klamath. Need to expand service area to include a member that falls outside of this service area to resolve.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Recent issue: Credentialing contracted providers, can only pay providers that are not credentialing contract rates.	Jeff
8.	Members Services, access issues, concerns, and updates. No access issues to report. New promotional material re-determination material arrived and are being sent out. Member services on track and ahead of schedule.	Tammie
9.	Adjourn	

NEXT MEETING
JULY 27, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

March 23, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Faith Lee; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlighted members absent.	
1.	Open Meeting; Approve Previous Month's Minutes Moved and approved Michael, David second.	Biagio
2.	Network Access PNM gave updates on Neurology and PA requirements, Orthodontia benefit update. Oral Surgery options and efforts to procure a telehealth specialty provider as well as new possible mental health prescribing provider.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel not present (lost to poor connection).	Chanel
4.	Medical updates, concerns, and access point issues. David nothing new for this month. Any neuro in state we won't deny them for being out of area. Easing PA requirement for ease of access.	David
5.	Appeals & Grievances updates.	Kim

	Kim W. not present.	
6.	Case Management gaps, concerns, and updates. Arthur's team asking for updates on losing providers i.e. Klamath Counseling closing, asking PNM share info as it comes.	Arthur
7.	Compliance and Provider related issues or updates. Credentialing and Contracting issues, concerns, and updates. Good progress on EQR and reminder that all is due to Compliance 4/3. OHA redoing Network Adequacy rules for 2024. Potentially we could apply for waivers but little to no information from OHA. Credentialing still having issues with [redacted] but getting better. OHA is undergoing a lot of internal turnover and slightly concerned about OHA operationally.	Jeff
8.	Members Services update. Welcome Tammie as new team lead (CSR III) for Member Services. Still looking at 6 months wait list for KHP, their dental access seems to be doing ok, issues remain that member waiting until having a dental emergency before seeking a dentist. Doing member outreach calls as well as secret shopper surveys.	Tammie

9. Adjourn

NEXT MEETING

APRIL 27, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

May 25, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlight = Absent	
1.	Open Meeting; Review and approve previous April Meeting Minutes. Arthur moves to approve, Tammie seconds	Biagio
2.	Network Access concerns and updates. PNM updates on dental providers, Ortho benefit provider Dr. Panchura singed contract to provide services for Ortho benefit. KHP hired 3 dentists to start in July and late August. Capitol dental has contract and reviewing documents. Several new BH provider contracts are in the que to be credentialed and added to the network.	Biagio
3.	Quality Metrics performance, access concerns and updates. No new updates. For next month add presentation regarding member inactivity data. David E to present to committee at June meeting. Currently there are	Chanel

	approximately 35% of assigned members permanently inactive. Either not seen within the last 2 years or assigned and never seen.	
4.	Medical updates, concerns, and access point issues. David, nothing new for May.	David
5.	Appeals & Grievances updates and concerns. Kim W. absent for May PNMC.	Kim
6.	Case Management gaps, concerns, and updates. Arthur, in home infusion services for outlying areas. Providence wants to contract with CHA. Currently we use SLMC as in town but not in-home and Quorum does discharge IV antibiotics and in-home. Issue with [redacted] and glucose pumps and supplies, having a coding issues resulting in some delay in members getting pump and supplies.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff, no new updates for May.	Jeff
8.	Members Services, access issues, concerns, and updates.	Tammie

	Tammie, still focused on re-determination, good progress with mailing lists and put flag in Essette to tell members their re-determination date. No other access issues. ***Note***: capacity and assignment slide; although SLPCC is not at capacity, they are currently not accepting new members unless they call to have a member assigned.
9.	Adjourn Meeting adjourned at 4:03 pm.
	NEXT MEETING **JUNE 22, 3:30-4:30 PM**

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

April 27, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow Highlighted = Member Absent	
1.	Open Meeting; Approve Previous Month's Minutes. David moves and Jeff Second.	Biagio
2.	Network Access concerns and updates. Discussed current access issues with Oral pediatric surgeons and working with Oregon Pediatric Dentistry Clinic via LOA's to avoid any bottle neck of CCO-F members. Reviewed quarterly updated slides that included data captured from Secret Shopper surveys. Discussed creating and adding CHA standards to eventual dashboards to further monitor clinics meeting said standards.	Biagio
3.	Quality Metrics performance, access concerns and updates. Discuss PCPCH weighted performance as it relates to unassigned members. Because of increase in membership weighted score is decreasing. Chanel also reviewed	Chanel

	updated Q1 language interpretive services slide. CHA seeing a lot more data from providers. CHA passed MLA measures and met the 80% OHA guideline benchmark. Dat being collected is more refined, however, working with clinics to have better updates on charts and further refining the data.	
4.	Medical updates, concerns, and access point issues. David: growing problems with provider performance with authorization. Creating operational issues because of missing information, incorrect information etc. Challenges with DME i.e. [redacted]. SLMC contracts with Pacific Medical and Synergy as a possible replacement or added DME supplier.	David
5.	Appeals & Grievances updates and concerns. Kim, Q1 G&A data coming in May meeting. Reviewed and discussed non-compliance of subcontracted/delegated entities of grievances captured and notice of same. Reviewed a sample from [redacted] and [redacted] to be put on corrective action plan (CAP) to monitor and resolve. Kim to initiate CAP from Q1 through Q4 2023 to monitor for correction. Both entities will have to report monthly through 2023 with CHA to oversee and ensure compliance. Jeff added that Compliance is looking to do	Kim

	more in person audit to help educate clinics on what is needed and help avoid future compliance issues.	
6.	Case Management gaps, concerns, and updates. Arthur not present.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff ramping up provider auditing. Credentialing delegated agreements compliance with contractual obligations. EQR submitted last week. Working at better efficiencies when it comes to auditing and administrative challenges for provider clinics.	Jeff
8.	Members Services, access issues, concerns, and updates. No new updates, current major focus is on re-determination efforts as this comes into focus for 2023-2024. Educating members on same.	Tammie
9.	Adjourn	
	NEXT MEETING **MAY 25, 3:30-4:30 PM**	

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

August 24, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Highlighted members absent.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Approved as amended.	Biagio
2.	Network Access updates and concerns. Biagio gave updates. Michael Sheet retiring. Michael D. Court Street responded and Dr. Haddad willing to contract for extractions for our members.	Biagio
3.	Quality Metrics performance, access concerns and updates. Michael for Chanel, Provider Engagement plan with Sherrie. Need to engage PNM on this.	Chanel- - ABSENT
4.	Medical updates, concerns, and access point issues. Sleep and Pulmonary wait time is up to year, David allowing reviewers to approve out of town PA's to help.	David

	Discussed D. Elliot's presentation last month. This is an under-utilization issue. David S. willing to come back to committee with a proposal on how to solve this.	
5.	Appeals & Grievances updates and concerns.	Kim ABSENT
6.	Case Management, gaps, concerns, and updates.	Arthur ABSENT
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Making good progress with SLMC on credentialing. Moving towards educating them to help expedite credentialing that is more efficient and complete. Concerns with OHA network adequacy changes. How they intend to monitor and police these changes.	Jeff
8.	Members Services, access issues, concerns, and updates.	Tammie ABSENT
9.	Adjourn	

NEXT MEETING

SEPTEMBER 29, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

January 26, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera; Dawna Oksen; David Shute; Leanne Rose; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji M	
1.	Open Meeting; Approve Previous Month's Minutes Michael noticed the error in Attendees that needs to be changed the attendees who actually attended and not those who were invited. Chanel to send PNM new CHA minutes template to implement in February and moving forward.	Biagio
2.	Network Access PNM gave access update; long discussion on BP cuffs, vendors and required educational piece that must be made in person. Medline as an option for immediate backlog solution. PNM Updated committee on new BH provider and possibility of a new Mobile dental clinic.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel commented that additional claims still incoming that will affect some of the performance metrics and at	Chanel

	least one (DHS Dental Assessment) will change from red to green to meet the annual target. Depending on the number of claims, Oral Assessment may also hit the target at well.	
4.	Medical updates, concerns, and access point issues. BP Cuff issue covered, no other concerns.	David
5.	Appeals & Grievances updates. Kim is working on Q4 update, will have that data to share and present in February meeting.	Kim
6.	Case Management gaps, concerns, and updates. BP Cuff concerns already discussed, otherwise no other updates.	Arthur
7.	Compliance and Provider related issues or updates. Credentialing and Contracting issues, concerns, and updates. Jeff & Faith PTO. Shelley commented on Credentialing items taking so long from providers and getting incomplete applications.	Jeff
8.	Members Services update.	Michael

Contracts and Compliance Meeting discussed network and adequacy standards are changing for 2024 contract. We would be considered a rural setting where Medford/Bend considered closest Urban area. Meeting set for February 2023.
9. Adjourn
NEXT MEETING **FEBRUARY 23, 3:30-4:30 PM**

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

July 27, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow = Absent	
1.	Open Meeting; Review and approve previous month Meeting Minutes. July slide deck update: errors found after they were sent, corrected revised deck will be sent to the committee. Jeff D. Moved to enter June minutes; David S. 2nd.	Biagio
2.	Network Access concerns and updates. PNM gave access update. No new movement on adding Capitol Dental; PNM updated PNMC on staffing improvement at Timber Kids; No significant changes in BH; PCP's extremely busy, otherwise no changes.	Biagio
3.	Quality Metrics performance, access concerns and updates. Chanel S. not present for July.	Chanel
4.	Medical updates, concerns, and access point issues.	David

	David S., no access concerns. Are we going to discuss David E. Presentation. This is an access concern. David mentioned to be approached to join a collaborative to recruit Providers. Early stages of development and want to have CHA as a part of it.	
5.	Appeals & Grievances updates and concerns. Kim W., no new updates.	Kim
6.	Case Management gaps, concerns, and updates. Arthur P., [redacted], additional feedback from Kim regarding [redacted] issues.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff D. briefly discussed data breach at Capitol dental, low impact to CHA members. Jeff D. briefly discussed data breach at Capitol dental, low impact to CHA members. Credentialing delegation agreements terminated. EQR audit went well, waiting for comments.	Jeff
8.	Members Services, access issues, concerns, and updates. Received negative feedback for lack of provider choice, approximately 10 to 15 members. Same with wait times on clinics. These are being sent to Kim for grievances.	Tammie

9. Adjourn

NEXT MEETING

AUGUST 24, 3:30-4:30 PM

PRIOR TO THIS AGENDA: **David Elliot** guest presenter on PCP Provider Inactivity. Provided data on Member that are either inactive for a period of time or never had an initial consultation being dropped from their provider as a result. Up to 35% of capitation not being utilized. Resulting unassigned members being seen at other PCP clinics. David reviewed raw data, by member and clinic population as compared to capitation PM/PM. Brief historical review of where members have been seen by year and clinic for services.

Continued discussion without David Elliot: David S. concerned this is an access issue. Suggested a contractual change. Another area of concern is the members that are in our Quality metrics pool and issues with the incentive metric areas. David S. would like to start to discuss interventions and to discuss this further. Clarification is needed as our clinics are reporting that they do not drop CHA members under for inactivity. Tammie S. will start keeping track of members and ID numbers for these members for further review. Kim will review grievances as well to track, valid and bring to committee.

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

June 22, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow= Absent Member	
1.	Open Meeting; Review and approve previous May Meeting Minutes. Move by: Jeff Second by: Arthur	Biagio
2.	Network Access concerns and updates.	Biagio
3.	Quality Metrics & Health Equity: performance, access concerns and updates. No metric issues. The MLA interpreter training, building up that network with OHA approved interpreters. Work on adding trainings with our providers to certify more. Language line actively recruiting interpreters. KOD PCP's leaving. Focus on replacements.	Chanel
4.	Medical updates, concerns, and access point issues. David Shute not present.	David
5.	Appeals & Grievances updates and concerns.	Kim

	No Q1 updates, dashboard issues. Will have next month. No other updates.	
6.	Case Management gaps, concerns, and updates. Member can't get a continuous glucose monitor, Byram saying we are out of network. That is not the case. Escalating to resolve. SLMC is the only home health provider in Klamath. Need to expand service area to include a member that falls outside of this service area to resolve.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Recent issue: Credentialing contracted providers, can only pay providers that are not credentialing contract rates.	Jeff
8.	Members Services, access issues, concerns, and updates. No access issues to report. New promotional material re-determination material arrived and are being sent out. Member services on track and ahead of schedule.	Tammie
9.	Adjourn	

NEXT MEETING
JULY 27, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

March 23, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Faith Lee; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlighted members absent.	
1.	Open Meeting; Approve Previous Month's Minutes Moved and approved Michael, David second.	Biagio
2.	Network Access PNM gave updates on Neurology and PA requirements, Orthodontia benefit update. Oral Surgery options and efforts to procure a telehealth specialty provider as well as new possible mental health prescribing provider.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel not present (lost to poor connection).	Chanel
4.	Medical updates, concerns, and access point issues. David nothing new for this month. Any neuro in state we won't deny them for being out of area. Easing PA requirement for ease of access.	David
5.	Appeals & Grievances updates.	Kim

	Kim W. not present.	
6.	Case Management gaps, concerns, and updates. Arthur's team asking for updates on losing providers i.e. Klamath Counseling closing, asking PNM share info as it comes.	Arthur
7.	Compliance and Provider related issues or updates. Credentialing and Contracting issues, concerns, and updates. Good progress on EQR and reminder that all is due to Compliance 4/3. OHA redoing Network Adequacy rules for 2024. Potentially we could apply for waivers but little to no information from OHA. Credentialing still having issues with SLMC but getting better. OHA is undergoing a lot of internal turnover and slightly concerned about OHA operationally.	Jeff
8.	Members Services update. Welcome Tammie as new team lead (CSR III) for Member Services. Still looking at 6 months wait list for KHP, their dental access seems to be doing ok, issues remain that member waiting until having a dental emergency before seeking a dentist. Doing member outreach calls as well as secret shopper surveys.	Tammie

9. Adjourn

NEXT MEETING

APRIL 27, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

May 25, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlight = Absent	
1.	Open Meeting; Review and approve previous April Meeting Minutes. Arthur moves to approve, Tammie seconds	Biagio
2.	Network Access concerns and updates. PNM updates on dental providers, Ortho benefit provider Dr. Panchura singed contract to provide services for Ortho benefit. KHP hired 3 dentists to start in July and late August. Capitol dental has contract and reviewing documents. Several new BH provider contracts are in the que to be credentialed and added to the network.	Biagio
3.	Quality Metrics performance, access concerns and updates. No new updates. For next month add presentation regarding member inactivity data. David E to present to committee at June meeting. Currently there are	Chanel

	approximately 35% of assigned members permanently inactive. Either not seen within the last 2 years or assigned and never seen.	
4.	Medical updates, concerns, and access point issues. David, nothing new for May.	David
5.	Appeals & Grievances updates and concerns. Kim W. absent for May PNMC.	Kim
6.	Case Management gaps, concerns, and updates. Arthur, in home infusion services for outlying areas. Providence wants to contract with CHA. Currently we use SLMC as in town but not in-home and Quorum does discharge IV antibiotics and in-home. Issue with [redacted] and glucose pumps and supplies, having a coding issues resulting in some delay in members getting pump and supplies.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff, no new updates for May.	Jeff
8.	Members Services, access issues, concerns, and updates.	Tammie

	Tammie, still focused on re-determination, good progress with mailing lists and put flag in Essette to tell members their re-determination date. No other access issues. ***Note***: capacity and assignment slide; although SLPCC is not at capacity, they are currently not accepting new members unless they call to have a member assigned.
9.	Adjourn Meeting adjourned at 4:03 pm.
	NEXT MEETING **JUNE 22, 3:30-4:30 PM**

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

February 23, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary.	
1.	Open Meeting; Approve Previous Month's Minutes January minutes approved and moved.	Biagio
2.	Network Access Discussed Extended Stay Center Oregon Vascular Specialists extended stay center.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel discussed and shared REALD data, breakdown between minorities, % of members that answered or declined to answer. Monitoring Sky Lakes for low self-identifying minorities. Data will be incorporated into Health Equity Dashboard and eventually shared with public via OHA. Standards for PCPCH are changing and we are keeping an eye on demographic breakdowns. New potential BH provider telehealth services specializing in LGBTQIA+ community	Chanel

	Medical updates, concerns, and access point issues.	David
4.	Slightly longer waits for local PCP, CMO approving authorizations for those clinics out of area to open access and reduce any barrier or wait times.	
	Appeals & Grievances updates.	Kim
5.	Kim W. updated committee on 2022 Q4 reporting top Grievances is dental and Timber Kids as they hire an additional provider. Some grievances also captured for PCP and BH, the latter mostly from residential care treatment incidents. Both average time in resolution and determination days improved in 2022, specifically average determination days down to 3.3 days from 4.74 days in 2021. Grievance & Appeals now collecting and capturing Authorization data to report on dashboards moving forward.	
	Case Management gaps, concerns, and updates.	Arthur
6.	No updates other than DME supplier for BP Cuffs. List of Oregon approved suppliers.	
	Compliance and Provider related issues or updates.	Jeff
7.	Credentialing and Contracting issues, concerns, and updates.	

	New Cactus software updated program/platform. FWA reporting submitted. No other updates at this time.	
8.	Members Services update. Currently Tammy is the new lead on customer services issues and linking any issues with PNM. Recent calls include who is the member assigned to. Discussed Secret Shopper Survey and raw data conversion into dashboard format.	Michael
9.	Adjourn	

NEXT MEETING
MARCH 23, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

November 28, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Moved by: Jeff, Second David	Biagio
2.	Network Access updates and concerns. Discussed Network access updates: Capitol Dental opening 12/1; a joint press release was issued 11/27. Two new possible orthodontic clinics and one new possible oral surgeon to augment oral surgery services. Discussed BH possible new project to expand Psychiatry. Briefly talked about LSCNW continuing to expand and hire both new providers and administrative staff. They have a ton of access. Discussed current unconfirmed lag time for appointments for Dermatology. Currently February for established patients and June for new patients.	Biagio
3.	Quality Metrics performance, access concerns and updates.	Chanel

	Discussed clinic check in's expanding those to include dental and BH as well. Those are going well and sharing any concerns /issues internally to expedite any resolutions. Focus is on outreach and on any changes internally i.e. PA process etc. Making communication more linear. Trying to capture as much information as possible i.e. new and/or dental providers and staffing, expanding access. Working to improve process on Flex Funds, sending updated communications to clinics to improve flow and reduce any hiccups.	
4.	Medical updates, concerns, and access point issues. Discussed dermatology, unconfirmed reports of long waits for members requesting appointments. Access for sleep studies and pulmonary, secret shopper survey calls found no issues.	David
5.	Case Management, gaps, concerns, and updates. Discussed DME concerns and the need to find another supplier.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates.	Jeff

	Received comments from HSAG, internal meetings set to discuss with each department. Improvement plan will be discussed as well. We are moving training platforms starting Q1 2024. Revamping our training, platform, and content.	
8.	Operations: access concerns and updates. Discussed issues with provider portal and Essette to resolve minor issues with IT. Discussed better IT platforms to better communicate and have better outreach to provider clinics. Provider portal has capabilities but not being utilized to its full potential.	Michael
9.	Members Services, access issues, concerns, and updates. Discussed new traffic on Capitol Dental joining the network next month. 25% of calls are provider related, 28% flex funds and remainder were new calls or inquiries i.e. transfer calls.	Tammie
10.	Adjourn	

NEXT MEETING

DECEMBER 28, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

October 26, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlight equals absent member.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Moved Jeff.	Biagio
2.	Network Access updates and concerns. PNM discussed current access updates: PCP, SLPCC open to new members; ORAL: Capitol dental opening clinic in December; Klamath Dental center opened to new bulk assignment through Q1, 2024; OIT still looking for new provider; SPECIALIST: Klamath Ortho added new surgeon; BH: LCS added 2 new providers, they are hiring a third and have plenty of access for additional members.	Biagio
3.	Quality Metrics performance, access concerns and updates. Discussed new dentist Dr. Randell signed on to help with Oral Evals.	Chanel

4.	Medical updates, concerns, and access point issues.	David absent
5.	Case Management, gaps, concerns, and updates. [redacted] dropping items without communication to CHA. Biagio and Arthur to meet on DME supplier to replace Medline. David and Arthur met with Southern Oregon Chiro seeking outcome data. Follow up meeting set.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Discussed new hire and compliance position, starting on or about 11/13 for onboarding and meeting with induvial departments. Credentialing: working through applications ensuring completeness of same to avoid bottleneck and/or repeated corrections.	Jeff
8.	Operations: access concerns and updates. Members services is staffing new members and interviewing candidates. Discussed outbound call slow down. Discussed call volume increase with oral provider questions. Discussed members being assigned to one clinic	Michael

	but seeing another provider for services. HIT roadmap update: Member engagement plan next steps.	
9.	Members Services, access issues, concerns, and updates.	Tammie absent
10.	Adjourn	
	NEXT MEETING **NOVEMBER 22, 3:30-4:30 PM**	

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

September 29, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Michael D. moved to approve.	Biagio
2.	Network Access updates and concerns. Dental update, OIT, discussed getting new dentist. Discussed new clinic coming to town, waiting on opening date. Discussed current dentures at OIT, they will be completed. Remaining dentures moving to Court St. Dentures. Discussed live seminar training, materials and how they aligned with audience, over all great feedback from attendees.	Biagio
3.	Quality Metrics performance, access concerns and updates.	Chanel

	Language interpretive dashboard, much better data capture, much better traction and overall response. Quality continuing to improve upon dashboards quarterly.	
4.	Medical updates, concerns, and access point issues. David nothing new to add at this time.	David
5.	Case Management, gaps, concerns, and updates. DME supplier. Arthur and Biagio to discuss list of suppliers received from Leanne and other options.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff, very happy with provider in person training. Hiring new position for P&P and compliance training and policy analyst.	Jeff
8.	Members Services, access issues, concerns, and updates. Went through Secret Shopper dashboard, much better feedback on calls, especially from BH and Specialist. Capturing more data and better able to track the new information for this quarter. Able to do 3 rounds of calls with all providers for this quarter. Discussed wait times and what clinics are accepting new members, which are not and	Tammie

	what wait times are for PCP and PCD clinics. Longer wait times for PCD. Specialist slide populated with new data from improved calls and better feedback. BH same as specialist.
9.	Adjourn
NEXT MEETING **OCTOBER 26, 3:30-4:30 PM**	

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

February 23, 2023
3:30-4:30 PM
Ring Central Meeting

Attendees	Biagio Sguera - PNMC Chair; Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Kim Walls; Arthur Petersen; Chanel Smith; Shelley M. Emary.	
1.	Open Meeting; Approve Previous Month's Minutes January minutes approved and moved.	Biagio
2.	Network Access Discussed Extended Stay Center Oregon Vascular Specialists extended stay center.	Biagio
3.	Quality Metrics performance concerns and updates. Chanel discussed and shared REALD data, breakdown between minorities, % of members that answered or declined to answer. Monitoring Sky Lakes for low self-identifying minorities. Data will be incorporated into Health Equity Dashboard and eventually shared with public via OHA. Standards for PCPCH are changing and we are keeping an eye on demographic breakdowns. New potential BH provider telehealth services specializing in LGBTQIA+ community	Chanel

	Medical updates, concerns, and access point issues.	David
4.	Slightly longer waits for local PCP, CMO approving authorizations for those clinics out of area to open access and reduce any barrier or wait times.	
	Appeals & Grievances updates.	Kim
5.	Kim W. updated committee on 2022 Q4 reporting top Grievances is dental and Timber Kids as they hire an additional provider. Some grievances also captured for PCP and BH, the latter mostly from residential care treatment incidents. Both average time in resolution and determination days improved in 2022, specifically average determination days down to 3.3 days from 4.74 days in 2021. Grievance & Appeals now collecting and capturing Authorization data to report on dashboards moving forward.	
	Case Management gaps, concerns, and updates.	Arthur
6.	No updates other than DME supplier for BP Cuffs. List of Oregon approved suppliers.	
	Compliance and Provider related issues or updates.	Jeff
7.	Credentialing and Contracting issues, concerns, and updates.	

	New Cactus software updated program/platform. FWA reporting submitted. No other updates at this time.	
8.	Members Services update. Currently Tammy is the new lead on customer services issues and linking any issues with PNM. Recent calls include who is the member assigned to. Discussed Secret Shopper Survey and raw data conversion into dashboard format.	Michael
9.	Adjourn	

NEXT MEETING
MARCH 23, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

November 28, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Moved by: Jeff, Second David	Biagio
2.	Network Access updates and concerns. Discussed Network access updates: Capitol Dental opening 12/1; a joint press release was issued 11/27. Two new possible orthodontic clinics and one new possible oral surgeon to augment oral surgery services. Discussed BH possible new project to expand Psychiatry. Briefly talked about LSCNW continuing to expand and hire both new providers and administrative staff. They have a ton of access. Discussed current unconfirmed lag time for appointments for Dermatology. Currently February for established patients and June for new patients.	Biagio
3.	Quality Metrics performance, access concerns and updates.	Chanel

	Discussed clinic check in's expanding those to include dental and BH as well. Those are going well and sharing any concerns /issues internally to expedite any resolutions. Focus is on outreach and on any changes internally i.e. PA process etc. Making communication more linear. Trying to capture as much information as possible i.e. new and/or dental providers and staffing, expanding access. Working to improve process on Flex Funds, sending updated communications to clinics to improve flow and reduce any hiccups.	
4.	Medical updates, concerns, and access point issues. Discussed dermatology, unconfirmed reports of long waits for members requesting appointments. Access for sleep studies and pulmonary, secret shopper survey calls found no issues.	David
5.	Case Management, gaps, concerns, and updates. Discussed DME concerns and the need to find another supplier.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates.	Jeff

	Received comments from HSAG, internal meetings set to discuss with each department. Improvement plan will be discussed as well. We are moving training platforms starting Q1 2024. Revamping our training, platform, and content.	
8.	Operations: access concerns and updates. Discussed issues with provider portal and Essette to resolve minor issues with IT. Discussed better IT platforms to better communicate and have better outreach to provider clinics. Provider portal has capabilities but not being utilized to its full potential.	Michael
9.	Members Services, access issues, concerns, and updates. Discussed new traffic on Capitol Dental joining the network next month. 25% of calls are provider related, 28% flex funds and remainder were new calls or inquiries i.e. transfer calls.	Tammie
10.	Adjourn	

NEXT MEETING

DECEMBER 28, 3:30-4:30 PM

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

October 26, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields. Yellow highlight equals absent member.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Moved Jeff.	Biagio
2.	Network Access updates and concerns. PNM discussed current access updates: PCP, SLPCC open to new members; ORAL: Capitol dental opening clinic in December; Klamath Dental center opened to new bulk assignment through Q1, 2024; OIT still looking for new provider; SPECIALIST: Klamath Ortho added new surgeon; BH: LCS added 2 new providers, they are hiring a third and have plenty of access for additional members.	Biagio
3.	Quality Metrics performance, access concerns and updates. Discussed new dentist Dr. Randell signed on to help with Oral Evals.	Chanel

4.	Medical updates, concerns, and access point issues.	David absent
5.	Case Management, gaps, concerns, and updates. Norco dropping items without communication to CHA. Biagio and Arthur to meet on DME supplier to replace Medline. David and Arthur met with Southern Oregon Chiro seeking outcome data. Follow up meeting set.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Discussed new hire and compliance position, starting on or about 11/13 for onboarding and meeting with induvial departments. Credentialing: working through applications ensuring completeness of same to avoid bottleneck and/or repeated corrections.	Jeff
8.	Operations: access concerns and updates. Members services is staffing new members and interviewing candidates. Discussed outbound call slow down. Discussed call volume increase with oral provider questions. Discussed members being assigned to one clinic	Michael

	but seeing another provider for services. HIT roadmap update: Member engagement plan next steps.	
9.	Members Services, access issues, concerns, and updates.	Tammie absent
10.	Adjourn	
	NEXT MEETING **NOVEMBER 22, 3:30-4:30 PM**	

CHA PROVIDER NETWORK MANAGEMENT COMMITTEE

September 29, 2023
3:30-4:30 PM
Meeting location: Ring Central

Attendees	PNMC Chair: Biagio Sguera – PNMC Members: Dawna Oksen; David Shute; Leanne Rose; Jeff Dover; Michael Donarski; Arthur Petersen; Chanel Smith; Shelley M. Emary; Marji McClay; Tammie Shields.	
1.	Open Meeting: Review and approve previous month Meeting Minutes. Michael D. moved to approve.	Biagio
2.	Network Access updates and concerns. Dental update, OIT, discussed getting new dentist. Discussed new clinic coming to town, waiting on opening date. Discussed current dentures at OIT, they will be completed. Remaining dentures moving to Court St. Dentures. Discussed live seminar training, materials and how they aligned with audience, over all great feedback from attendees.	Biagio
3.	Quality Metrics performance, access concerns and updates.	Chanel

	Language interpretive dashboard, much better data capture, much better traction and overall response. Quality continuing to improve upon dashboards quarterly.	
4.	Medical updates, concerns, and access point issues. David nothing new to add at this time.	David
5.	Case Management, gaps, concerns, and updates. DME supplier. Arthur and Biagio to discuss list of suppliers received from Leanne and other options.	Arthur
7.	Compliance and Provider related issues and updates. Credentialing concerns, and updates. Jeff, very happy with provider in person training. Hiring new position for P&P and compliance training and policy analyst.	Jeff
8.	Members Services, access issues, concerns, and updates. Went through Secret Shopper dashboard, much better feedback on calls, especially from BH and Specialist. Capturing more data and better able to track the new information for this quarter. Able to do 3 rounds of calls with all providers for this quarter. Discussed wait times and what clinics are accepting new members, which are not and	Tammie

	what wait times are for PCP and PCD clinics. Longer wait times for PCD. Specialist slide populated with new data from improved calls and better feedback. BH same as specialist.
9.	Adjourn
NEXT MEETING **OCTOBER 26, 3:30-4:30 PM**	

Pharmacy and Therapeutics Committee Charter

I. CHARTER STATEMENT

The Pharmacy & Therapeutics Committee (P&T) is created and charged by Cascade Health Alliance Board of Directors to develop a formulary of pharmaceutical agents, review such formulary on a periodic basis, and make additional recommendations regarding the formulary as the Committee deems necessary and appropriate.

II. PURPOSE:

The purpose of the Pharmacy & Therapeutics Committee is to:

1. Ensure access to clinically sound and cost-effective medications.
2. Oversee the effective and efficient operation of the formulary system and drug policy development.
3. Make formulary recommendations that minimize therapeutic redundancies and maximize cost effectiveness.
4. Develop and manage policies for formulary management activities including prior authorization, step therapies, quantity limitations, and other drug utilization activities that affect access.
5. Support the establishment of procedures to assist CHA in executing and implementing operational performance improvement initiatives.

III. SCOPE:

The P&T Committee will serve in an evaluative, educational, and advisory capacity that will focus on actions that will encourage the use of safe and effective use of pharmaceutical agents that will produce the desired outcomes of drug therapy in a cost-effective manner.

IV. RESPONSIBILITIES

Responsibilities of the P &T Committee include, but are not limited, to the following:

- Periodically conduct therapeutic drug class reviews.
- Consider the relative safety, effectiveness, cost, and other pertinent factors in recommending pharmaceutical agents to be included in the formulary.
- Recommend an implementation period and medical necessity criteria for all pharmaceutical agents placed on the non-formulary status.
- Identify pharmaceutical agents for prior authorization and recommend the prior authorization criteria.
- Identify pharmaceutical agents for quantity limits and recommend the appropriate criteria.

V. MEETINGS

The P & T Committee will meet on a regular basis, but no less than every four months. Additional meetings may be called by the Pharmacy Director to address critical issues in a timely manner.

The Pharmacy Director will set meeting dates, times, locations and agendas.

VI. MEMBERSHIP

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

- Practitioners engaged in active practice from a variety of specialties who participate in the medication-use process.
- Chief Medical Officer
- Director of Pharmacy
- Clinical Pharmacist(s)

VII. TERM

Committee Chair's term will be limited to two years. Composition shall be reviewed from time to time, as necessary to reflect CHA's evolving organizational structure and the oversight needs of our business.

Role of a P & T Committee Member

It is intended that the P &T Committee leverage the experiences, expertise, and insight of key individuals across a wide spectrum of health care specialties. Individual 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 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 P &T Committee meetings on a regular basis.
- Actively engage in a forum to work together to improve health care delivery to members served by Cascade Health Alliance.

VIII. MEETING STANDARDS

1. QUORUM - a quorum shall exist with an absolute number of three members in attendance.

2. GUESTS - the Director of Pharmacy 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 a designee of the Pharmacy Director and be identified as the meeting "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. CHARTER REVIEW

This charter shall be reviewed annually. Material revisions to the Charter shall be approved by Cascade Health Alliance Board of Directors.

Cascade Health Alliance
P&T Virtual Meeting
April 19, 2023

Present: Dr. Cofas, Dr. Chase, Dr. Wirsing, Dr. Akins, Dr. Spicher
CHA: Amin Surani, Kelli Tompkins (Recording Secretary)

Minutes for December 13, 2022 were approved as written.

Formulary Reviews:
Additon of Acne medications to formulary were approved.
Amjevita ("low cost") was added to formulary with a PA.
Zavzpret was maintained as non-formulary.
Airsupra was maintained as non-formulary.
Brenzavvy was maintained as non-formulary.

Guideline Reviews:
Pharmacy and Therapeutics Committee Charter was approved.
Acne Medication Guidelines were approved.
2023 GOLD COPD Guidelines were approved.

Additional Business Discussion:
EPSDT (Early and Periodic Screening, Diagnostic & Treatment Benefit).
Hepatitis C outreach update.
Mail Order Pharmacy update.

Respectfully Submitted

Dr. C. Keith Cofas

Kelli Tompkins, Recording Secretary

Cascade Health Alliance
P&T Virtual Meeting
November 15, 2023

Present: Dr. Cofas, Dr. Chase, Dr. Wirsing, Dr. Akins, Dr. Spicher

CHA: Amin Surani, Dr. Shute, Dr. Peterson, Kelli Tompkins (Recording Secretary)

Minutes for September 20, 2023, were approved as written.

Formulary Reviews:
Pradaxa was approved.
Xarelto was maintained as formulary, no PA required.
Eliquis was maintained as formulary, no PA required.
Arexvy was approved with QL and AGE restriction.
Abrysvo was approved with QL and AGE restriction.

Additional Business Discussion:
Diabetic and Respiratory Supplies.
DUR Summary Q4 2023 (statins in presence of diabetes).
Updated prior authorization process.
Provider communication.
Steglatro shortage.

Respectfully Submitted

C. Keith Cofas MD 11/28/23
Dr. C. Keith Cofas

Kelli Tompkins CPh-T
Kelli Tompkins, Recording Secretary

Cascade Health Alliance
P&T Virtual Meeting
September 20, 2023

Present: Dr. Cofas, Dr. Chase, Dr. Wirsing, Dr. Akins
CHA: Amin Surani, Dr. Shute, Malea Waldrup, Kelli Tompkins (Recording Secretary)

Minutes for April 19, 2023, were approved as written.

2023 ADA Guidelines for Diabetes presentation - Ralph Eccles, DO, Physician, Klamath Health Partnership

Formulary Reviews:

Trulicity was approved with a PA.

Ozempic was approved with a PA.

Brenzavvy was approved with a PA.

Byetta was maintained as non-formulary.

Rybelsus was maintained as non-formulary.

New Drug Reviews:

Neffy—review only, no action taken.

Additional Business Discussion:

DUR Summary Q1 2023 (Statins); Q2 2023 (Heart Failure); Q3 2023 (Asthma).

Review of DUR for "Concurrent Prescribing of Opioids and Benzodiazepines".

Review of prescriber requirements for checking PDMP on Schedule II-controlled substances.

Update on transition of diabetic supplies to retail and mail order pharmacies.

Respectfully Submitted

C Keith Cofas 10/11/2023
Dr. C. Keith Cofas

Kelli Tompkins
Kelli Tompkins, Recording Secretary

ACTIVE MEMBER DEMOGRAPHICS

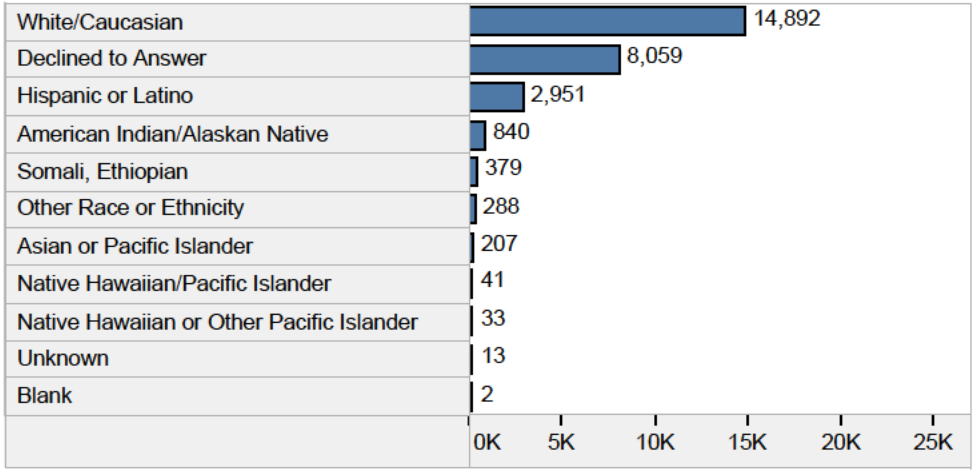
Cascade Health Alliance

1/1/2024

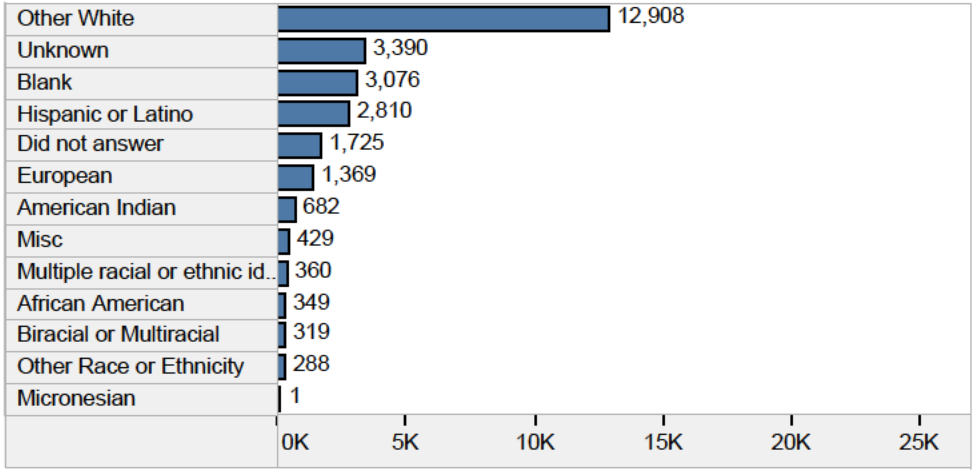
Race	All	**Ethnicity**	All	**Language**	All
City	All	**Age**	All	**Health Plan**	All

Total Members	Total Males	Total Females	Members with Disability	Dual Eligible Members
27,705	13,310	14,395	2,235	2,312

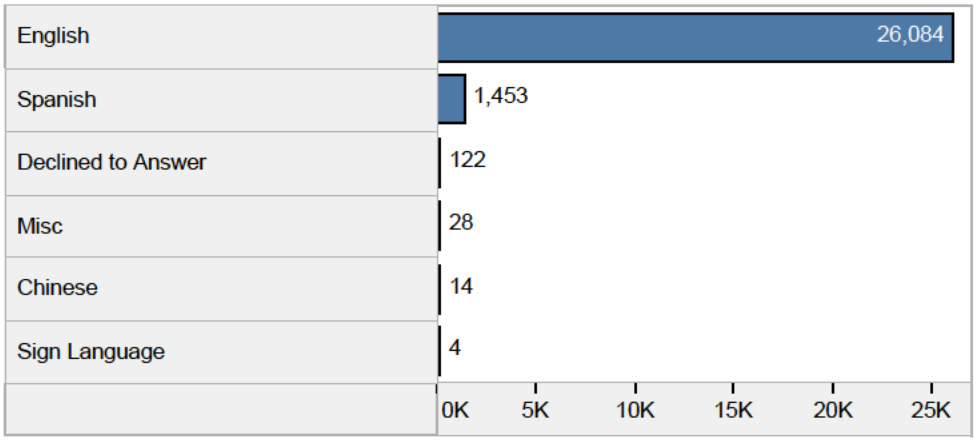
Members by Race



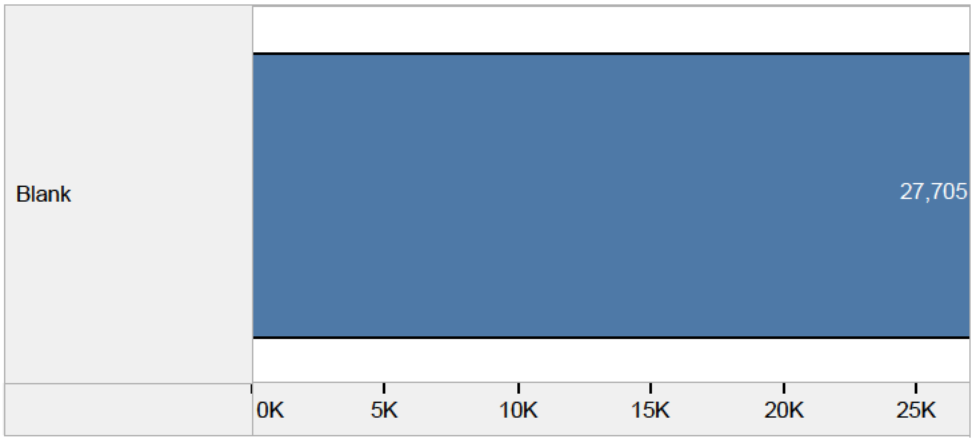
Members by Ethnicity



Members by Language



Members by Marital Status



Membership: Active Members on 12/31/2023 **Updated:** 1/1/2024 **Source:** Plexis and Reliance

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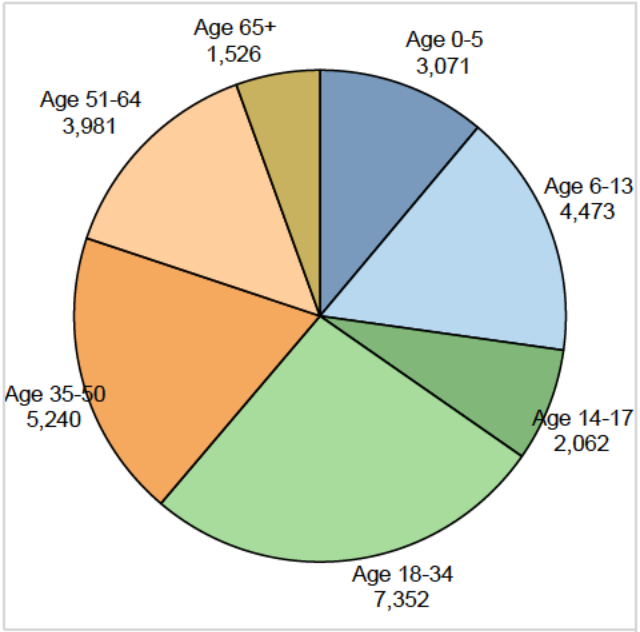
ACTIVE MEMBER DEMOGRAPHICS

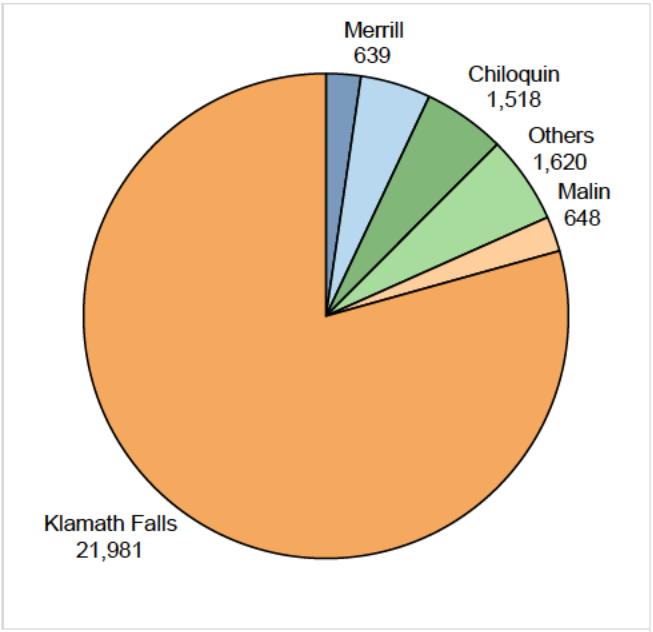
Cascade Health Alliance

1/1/2024

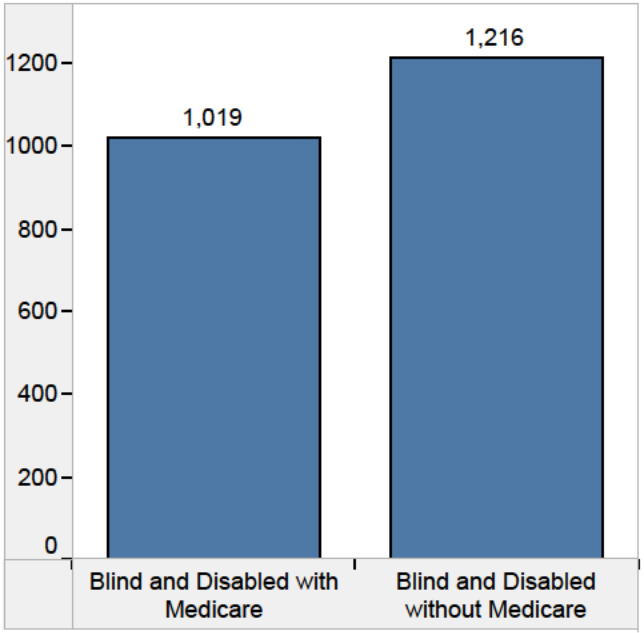
Members by Age Bin



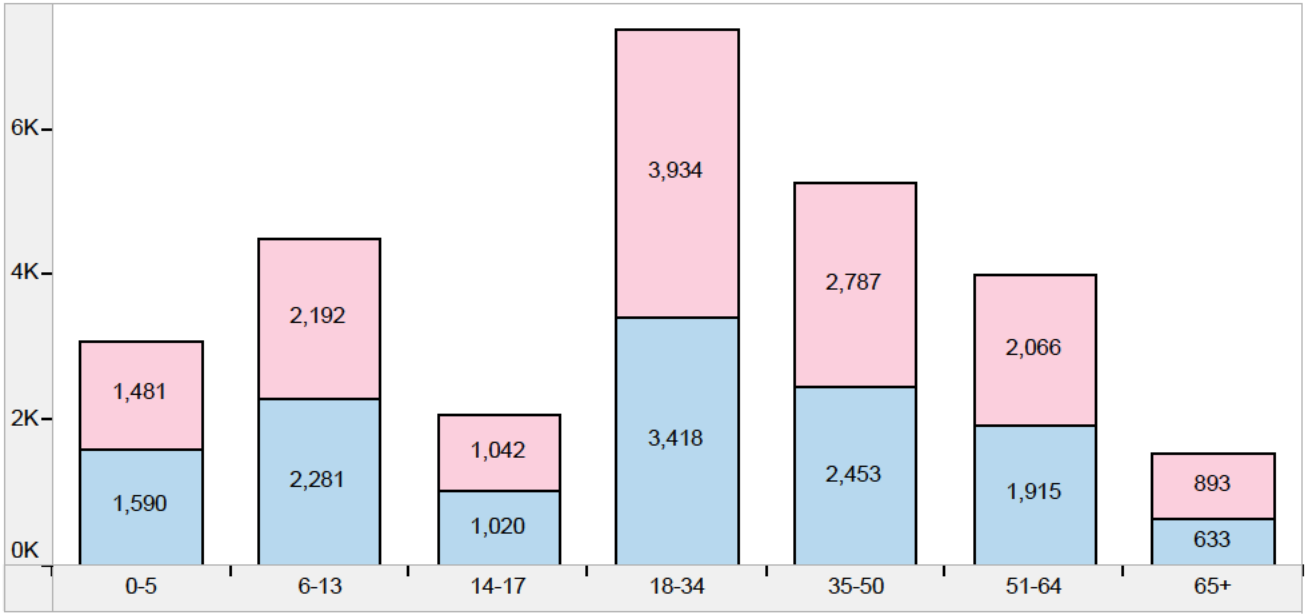
Members by Location



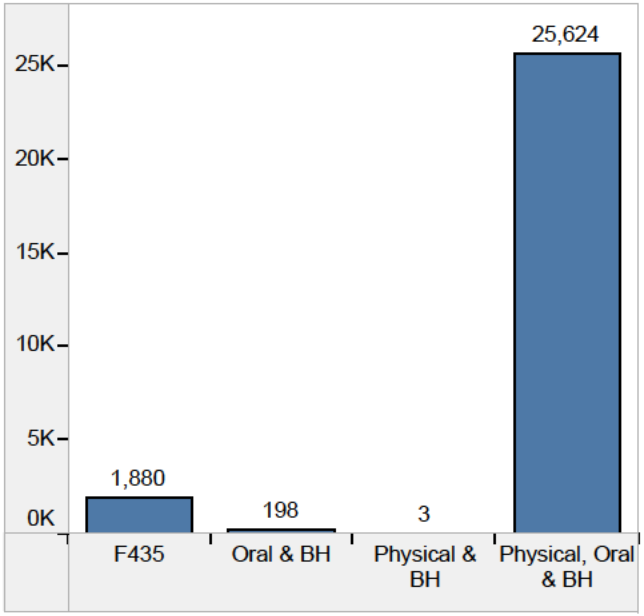
Members with Disability



Member Gender by Age Bin



Members by Benefit Plan



Membership: Active Members on 12/31/2023 **Updated:** 1/1/2024 **Source:** Plexis and Reliance

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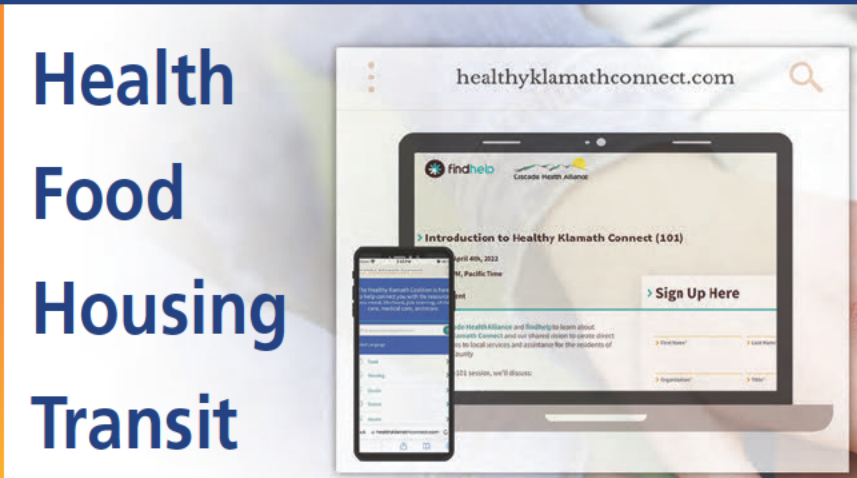
Need help?
Find help.

Search community resources at HealthyKlamathConnect.com

Find and connect with services for:



Health

Food

Housing

Transit

Employment

And much, much more…

HealthyKlamathConnect.com

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Person-Centered Primary Care Home (PCPCH) Comprehensive Plan

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

1 PURPOSE

1.1 Describes the plan CCC will follow to support primary care clinics with PCPCH tier advancement and increase CHA member enrollment in higher PCPCH clinics.

1.2 Describes how CCC will align efforts with PCPCH standards when collaborating with PCPCH clinics.

2 SCOPE

2.1 Includes CCC staff, CCC members, and PCPCH clinics.
2.2 Includes a learning collaborative with technical assistance (TA) opportunities, member education, and value-based payments.

3 PROCESS

3.1 PCPCH Learning Collaborative – Utilize a PCPCH learning collaborative to share best practices and align efforts to improve member experience.
- 3.1.1 Develop, test, review, implement, and establish learning collaborative structure.
  - 3.1.1.1 Prioritize topics/standards in the following order:
    - 3.1.1.1.1 Degree of alignment with other CCC initiatives
    - 3.1.1.1.2 Degree of relation to member experience
    - 3.1.1.1.3 Topics/standards PCPCH clinics struggle with
  - 3.1.1.2 Create schedule for six (6) months at a time.
    - 3.1.1.2.1 Included as standing agenda item during Metrics Workgroup.
    - 3.1.1.2.2 Meetings are held monthly with the intent that 100% of PCPCH clinics participate.
      - 3.1.1.2.2.1 The learning collaborative targets current PCPCH clinics while encouraging the participation of other network providers (non-PCPCH primary care, specialty, behavioral health, and oral health providers).
  - 3.1.1.3 Technical assistance (TA) opportunities are offered as needed.
- 3.1.2 Quarterly article submissions the Care Talk provider newsletter will relate to topics discussed during learning collaborative meetings.

3.2 PCPCH Member Education - Develop and use member education materials to increase member awareness of the benefits of belonging to a PCPCH for improving patient care and health outcomes.
- 3.2.1 PCPCH information is included in the CHA Member Handbook.
- 3.2.2 Develop PCPCH pamphlet.
  - 3.2.2.1 QM review and approve PCPCH pamphlet.
  - 3.2.2.2 Community and Public Relations, OHA, and others if needed review and approve PCPCH pamphlet.
  - 3.2.2.3 PCPCH pamphlet printed by vendor in color or internally in black and white.
    - 3.2.2.3.1 The goal is for 100% of new members are sent pamphlet in new member packets for three months.
      - 3.2.2.3.1.1 After three months, QM will evaluate if printed pamphlets are effective and if CCC should continue using pamphlets.
- 3.2.3 Add PCPCH information to CCC website.
- 3.2.4 Create, review, and approve PCPCH text.
  - 3.2.4.1 Text includes link to PCPCH information on CCC website.
  - 3.2.4.2 Send text to all CHA members with physical health coverage.

3.3 PCPCH Value-Based Payments – CHA's Value-Based Payment model includes a tiered-bonus payment for PCPCH certification, starting at the tier-3 level with increasing payments to the 5 Star level.

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3.4 Review PCPCH Comprehensive Plan annually and update as needed.

4 APPENDIX <or APPENDICES> <delete if not required>

4.1 CHA Member Handbook: https://www.cascadehealthalliance.com/for-members/member-handbook/
4.2 CHA Website PCPCH: https://www.cascadehealthalliance.com/for-members/member-benefits/patient-center-primary-care-homes-pcpch/
4.3 PCPCH: https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx
4.4 Transformation and Quality Strategy (TQS): https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx
4.5 TQS Technical Assistance (TA): https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

DRAFT

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Cascade Health Alliance, LLC

cascade comprehensive care, inc.

PATIENT CENTERED PRIMARY CARE HOME POLICY AND PROCEDURE

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

CONTENTS

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 CCC Glossary.

1 PURPOSE

1.1 This policy and procedure establishes standards to ensure members receive access to integrated, culturally and linguistically appropriate patient-centered care and services (physical, behavioral, and dental).

2 SCOPE

2.1 This policy acts as a guide to assure that Members are fully informed partners in transitioning to and maximizing the benefits of the Patient-Centered Primary Care Home (PCPCH) model of care.

3 POLICY STATEMENT

3.1 Member Services Department will:

3.1.1 Provide each Primary Care Provider (PCP)/PCPCH with a current member assignment/reassignment list daily.

4 PROCEDURE

4.1 The Medical Director will:

4.1.1 Contact each provider/clinic regularly to determine total number of enrollees they will accept based on provider availability.

4.1.2 Monitor local and out of area needed specialists for availability and access.

4.2 PCP/PCPCH will:

4.2.1 Provide written notice to CHA at least 90 days prior, of provider's intent to close his/her practice to all new patients.

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4.2.2 Providers may not close his/her practice to new members while continuing to accept new patients from other plans, if they have not filled their agreed upon capacity with CHA.

5 RESPONSIBILITIES

5.1 If we intend to terminate a health care provider or group, resulting in a significant impact on access to care, we will give Oregon Health Authority (OHA) 90 days' notice prior to the date of termination. If a provider or group is going to terminate and fails to provide the required 90 days' notice or there are problems that could compromise member care, we will give notice to OHA as soon as information is available.

Compliance, Monitoring and Review

5.2 The Member Services department will monitor the provider panel for access to primary care and specialty care on a monthly basis. This includes identifying availability of cultural and linguistic capabilities of provider/staff, the number of enrollees the provider is currently serving and the additional capacity for new enrollees.

5.3 The Compliance Management department will monitor the complaint logs for issues regarding PCP/PCPCH choice, assignment and reassignment.

5.4 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.

Reporting

5.5 The Compliance Department will conduct access and appropriateness of care audits for each PCP/PCPCH and/or clinic on an annual basis.

Records Management

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

6 DEFINITIONS

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Contract # 143110-11

7.2 Health Insurance Portability and Accountability Act (HIPAA)

7.3 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	Executive Approval Committee
Committee Review Dates	10/10/2018
Approval Dates	10/15/2018

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Cascade Health Alliance

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ATRIO CHA Collaborative Workflow

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

1 PURPOSE

1.1 The purpose of this workflow is to create a pathway for collaborative communication between Atrio and CHA Case Management (CM) around dual eligible special needs population (DSNP) members who may need case management services from both. It will include referrals to CHA CM from Atrio and sharing of Health Risk Assessments (HRAs), Care plans, and contact and progress notes between the two lines.

1.2 This workflow enables CHA and Atrio CM to prioritize members receiving long-term services and supports (LTSS).

1.3 This workflow includes service provision, coordination, follow up, and monitoring of members.

1.4 This workflow will enhance the reduction of duplication of services (including services related to discharge planning for short-term and long-term hospital and institutional stays).

2 SCOPE

2.1 Collaboration related to case management and data sharing between Atrio Health Plans (Atrio) and Cascade Comprehensive Care (CCC).

- 2.1.1 Atrio is a Medicare Advantage (MA) organization with Preferred Provider Organization (PPO) plans and Dual Eligible Special Needs Plans (DSNP).
- 2.1.2 CCC is a health care management company that operates Klamath County's coordinated care organization (CCO), Cascade Health Alliance (CHA), and serves as a local administrator for Atrio.

2.2 Case management department at CCC.

- 2.2.1 The case management department at CCC includes CHA and Atrio staff.

2.3 Coordination includes, but is not limited to, 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.

2.4 This workflow focuses on DSNP members, a subpopulation of CHA's Full Benefit Dual Eligible (FBDE) population.

- 2.4.1 DSNP members have both CHA and Atrio insurance.
- 2.4.2 DSNP population includes members with special health care needs (SHCN), including but is not limited to long-term services and supports (LTSS).
  - 2.4.2.1 The LTSS population is a subpopulation of the LTSS members captured through CHA Memorandum of Understanding (MOU) reporting.
- 2.4.3 Any FBDE member could potentially because a DSNP member.

3 PROCESS

3.1 Referral to CHA CM from Atrio

- 3.1.1 Atrio CM identifies DSNP member with intensive care coordination needs.
  - 3.1.1.1 High health care needs

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LTSS Process along with all attachments hereto shall be considered
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3.1.1.2 Multiple chronic conditions
3.1.1.3 Mental illness or substance abuse disorders
3.1.1.4 Functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities
3.1.1.5 LTSS members who otherwise meet Special Health Care Need (SHCN) population as defined by the OAR
3.1.1.5.1 APD notifies CHA monthly who the CHA LTSS members.
3.1.1.5.2 Using APD's insurance flag, CHA sends Atrio a monthly list to identify who the DSNP LTSS members are
3.1.1.5.3 Atrio identifies if Atrio CM or CHA CM needs to actively engage with DSNP LTSS member

3.1.2 Referral for CHA case management is emailed to Clinical Operations Manager and CCC Director of Clinical Operations, with attached copy of most recent Atrio HRA.
3.1.3 Summary of member needs will be included in referral.
3.1.4 Atrio CM documents in Atrio Member chart that referral has been placed to CHA for on-going case management.

3.2 CM and UM Manager will assign referral to CHA CM, upload the HRA to the member CHA CM chart.
3.3 CHA Case Manager will verify acceptance of referral, and channel of communication through email or Teams will be opened between Atrio/CHA CMs.
3.4 CM will process referral according to standard case management pathways, beginning with screening.
3.4.1 The purpose of attaching the Atrio HRA is to allow CHA CM to review and prefill CHA HRA with existing information to not duplicate the query with the member.
3.5 Comprehensive data monitoring and analysis plan to include, but is not limited to:
3.5.1 Outreach efforts and members engaged in services
3.5.2 Services provided. Care plan/goals are developed.
3.5.3 Members served and being actively case managed
3.5.4 ED utilization
3.5.5 Depression Screening and Follow-up
3.5.6 Plan All-Cause Readmissions
3.5.7 Change of condition (drastic)
3.5.8 Chronic diseases (including, but are not limited to, diabetes, congestive heart failure, asthma, and COPD) and complications of and health outcomes related to those chronic diseases)
3.6 Mutual accessibility to all necessary member information and reporting.
3.6.1 CHA CM attends all IDT meetings. Atrio CM is invited to all IDT meetings.
3.6.2 Care plan is emailed to Atrio CM monthly or as applicable.
3.6.3 Case closure and reasons for closure.
3.6.3.1 Atrio CM will add these notes and updates to the Atrio chart as a valid action.
3.6.4 Atrio CM will share additional information with CHA CM as applicable.
3.7 All collaborative care between CHA and Atrio CM will aid in further development related to:
3.7.1 Identification of improvement opportunities to improve health outcomes, target health disparities, reduce all-cause readmissions, increase screening for depression and follow-up, and decrease avoidable emergency room utilization

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LTSS Process along with all attachments hereto shall be considered
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3.7.2 Formal staff training curriculum development based on Atrio's SNP Model of Care (MOC)
3.7.3 Mutual accessibility to all necessary member information and reporting
3.7.4 Regular review of current processes and workflows for service provision, coordination, follow up, and monitoring of members
3.7.5 Streamlining processes to improve data capture, contact with and screening of LTSS and other SHCN members, and care coordination as well as standardize communication.

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LTSS Process along with all attachments hereto shall be considered
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CCO-LTSS Partnerships MOU Template:

MOU Period: January 2024 thru December 31, 2025

Effective Date: As signed and dated below

Submit your CCO's CCO-LTSS MOU to CCO.MCODeliverableReports@state.or.us.

CCO Name: Cascade Health Alliance **OHA Contract # 161756-22**

Partner APD District (s) Names/Locations: Aging and People with Disabilities (APD) District 11 Klamath Falls, Oregon

If more than one AAA/APD office in your CCO Geographic Region Please Circle or X Whichever Applies: Single Combined MOU_**X**__ Multiple MOUs___

CCO – LTSS MOU Governance Structure & Accountability:

CCO Lead(s):	APD/AAA Lead(s):
CCO will clearly articulate: How CCO governance structure will reflect the needs of members receiving Medicaid funded Long-Term Services and Supports (LTSS), for example through representation on the governing board, community advisory council or clinical advisory panel. How Affiliated MA or DSNP plan participates in the MOU work for FBDE.	**AAA/APD will clearly articulate:** How AAA/APD governance Lead(s) for participation at the community level in the board / Advisory panel for LTSS perspective/Care Coordination AAA/APD will articulate how the membership of the local governing boards, Advisory Councils, or governing structures will reflect the needs of members served by the regional CCO(s).

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CCO-LTSS APD/AAA MOU(s): See MOU Worksheets for additional detail on MOU expectations in each domain

MOU Service Area:				
Shared Accountability Goals with APD/AAA or ODDS: Domain Addressed	**CCO Agreed to Processes & Activities**	**LTSS Agency Agreed to Processes & Activities**	**Process Monitoring & Measurement: Specific Identified Local Identified Measures of Success**	**Annual Report on Specific Statewide Measures of Success (provide data points*) — monthly & annual [REQUIRED data points at minimum}**
DOMAIN 1: Prioritization of high needs members				
DOMAIN 1 Goals: Prioritization of high needs members Aligned definition and prioritization of high needs members.	1. CCO performs health risk assessment for all new members which identifies new members receiving LTSS and screens for care coordination needs. *Prioritization is also identified through CHA CM analysis of the monthly LTC consumer list provided by APD. LTSS consumers are identified in CHA EMR through an LTSS flag in the demographics window of the individual chart.* CHA and APD agree to identify high need members by considering these identification factors: • APD SPL levels 1 – 13	1. APD makes referrals to CHA for members with potential need for care coordination or when APD staff identify concerns or changes in health status which are considered high needs. 2. APD provides CHA a monthly LTC report for members in common (including DSNP) receiving long term services and supports. 3. CHA and APD factor in relevant summary acuity and screening information to identify high needs members for potential care conference/staffing. 4. APD will update CHA regarding consumers needing increased service coordination.	Process Monitoring: 1. Bi-Monthly collaboration meetings identify members needing CHA CM/outreach or members needing referrals for APD screening. 2. *CHA members are provided and are encouraged to complete a standardized Health Risk Assessment. Questions on this assessment are weighted to give a quantitative score, indicating what level of Case Management Outreach is required. All members receiving LTSS are captured under the prioritized population.* 3. *As* ***Measurements:***	# of members with LTSS that prioritization data was shared during each month/year Annual Average monthly # of members with LTSS for whom prioritization data was shared [monthly #/total in year]— calculated by OHA from data submitted # of CCO referrals to APD/AAA for new LTSS service assessments (for persons with unmet needs) # of APD/AAA referrals to CCO for ICC review # of completed referrals for ICC review [Monthly/Year Total]

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	• ER and Hospital Utilizations *HIE Collective Medical now flags CHA and DSNP members that are identified in the monthly LTC list provided by APD. LTSS members who have ED encounters or hospitalizations are reviewed by CHA CM. APD is notified when consumer is opened to Case Management.* Individuals with high needs are identified, they are staffed in CHA/APD IDT meetings. Follow up/monitor referral outcomes at least monthly. • Complex Conditions • Claims Data • Mental/Behavioral Health • Chemical Dependency • Complicating Circumstances • Client self-referral Based on the above health risk assessment, CCO will make referrals to its case management team *for outreach* as needed.	5. Information is shared at least bi-monthly during regular cadence of meetings *regarding need for additional services, high medical utilization and/or resolved issues* and successes.	*4. # of members receiving LTSS identified through HIE as having high ED or hospital utilization* *5. # of those members outreached by CHA for CM* *6. # of those members discussed at IDT months* 7. Number of referrals *between APD and CHA since the prior meeting*	

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	2. *Screening is re-evaluated annually or following a known triggering event to ensure member risk is accurately identified. Review of scoring from LTC report also shows any change in member needs/abilities.* 4. *CCO notifies APD of consumer engagement with CHA CM through referral form sent via a secure email or fax line, (listed in the Case Management electronic file LTSS> Resources).* *(See attached referral form.)*			
DOMAIN 2: Interdisciplinary care teams				
DOMAIN 2 Goals: Interdisciplinary care teams	*CCO will identify consumers with high ED utilization/hospitalizations and refer to APD for assessment of changed needs.* 1. *CCO follows workflow for identifying and responding to prioritized members.* 2. CCO notifies APD of any triggering event such as HEN that may result in CM services. HEN will be discussed at bi-weekly Interdisciplinary (IDT) meetings and APD will be updated if CM services	APD periodically sends *CHA LTSS Project Manager an updated APD service coordinator* contact list to support with case coordination. *This list is added to the LTSS > Resources Tab in CM files.* 1. APD will identify non-traditional health care providers such as Long Term Care Community Registered Nurse (LTCCRN), HCW and Caregivers if applicable. 2. APD has Diversion Transition workers who attend weekly SNF care conferences and will share information with the CCO TOC care		# of members with LTSS that are addressed/staffed via IDT meetings monthly % of months where IDT care conference meetings with CCO and APD/AAA occurred at least twice per month total annual IDT meetings completed by CCO-APD/AAA teams

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	were started. Copy of members care plan will be provided to APD. 3. CCO Case Management collaborates with member, member representatives, providers, LTCCNs, DSNP CM, other interested parties and APD case managers through regular, scheduled bi-weekly meetings. *4.Parties will be notified of upcoming IDT meetings which may be held in person or virtually, by email invitations.* *5. Care plans are reviewed, updated and distributed following CHA CM Model of Care.* 6. CCO will share person-centered care plans and updates with agency CM or LTCCN through *secure email and/or* IDT meetings.	coordination team and inform the care team how to make referrals to APD. 3. Diversion Transition workers will narrate in APD case records and share information with case managers/supervisors via secure-mail. 4. APD will identify individuals for care conferencing and staffing referrals. 5. APD will commit to attending care conferences/staffing meetings to keep the process relevant and to review outcomes. 6. APD will visit with member or members representative in person, by phone or virtual platform to establish care transition, goals, preferences and supports needed. 7. APD will inform CCO of services being provided by APD during IDT meetings		% of times consumers participate/attend the care conference (IDT) by month/year % of consumers that are care conferenced/total number of CCO members with LTSS (percentage of LTSS recipients served by CCO)
DOMAIN 3: Development and sharing of individualized care plans				
DOMAIN 3 Goals: Development and sharing of individualized care plans	CCO develops person-centered care plans based on comprehensive assessment of member which includes health history, medication reconciliation, need for advanced care planning, identifies BH needs, SDOH,	APD will provide education and training to CCO CM staff as APD processes change and are updated.	Process Monitoring: 1. CCO will perform random member care plans audits to ensure goals and interventions reflect member needs.	% of CCO individualized person-centered care coordination plans for CCO members with LTSS that incorporate/document member preferences and goals % of CCO person-centered care plans for members with LTSS

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	language preferences and accessibility needs with member's identified needs and preferences and agreement to any referrals made to community partners on behalf of the member. This is a standardized process for all CHA and DSNP members, including LTSS-CHA/DSNP members enrolled in a CHA CM Program. CCO ICC CM care plans are reviewed monthly or if triggering event or change of condition is noted, and if needed, updated to reflect ongoing or new needs. Member goals are reviewed at least monthly with member and during IDT meetings. CHA shares person-centered care plans and updates with agency CM or LTCCN during regular IDT meetings and with member and providers as updates and/or changes occur or upon request.	1. APD agrees to share CAPS assessments and relative service plan information. 2. APD will participate in bi-weekly collaborative meetings to share and receive updated information of care and care needs. 3. APD will engage members in their care planning when appropriate. --Identifies how APD/AAA supports the flow of relevant information into shared care planning; implement a standardized approach to effectively plan, communicate, and implement care planning and follow-up -- Defines how APD/AAA will share key health-related information, including risk assessments generated by LTSS providers and local Medicaid AAA/APD offices into CCOs' individualized care plans development for members with intensive care coordination needs. --Explains how care plans are shared and updated among care team members, expectations for how often care plans are reviewed, triggers for updates. -- Documents how individuals are involved in care planning and ensures beneficiaries are treated fairly, are informed of their choices, and have a	2. APD will track CAPS Assessments needed for consumers care planning. Measurements: 1.APD will Track number of CAPS assessments done as a result of CHA referrals. 2.CHA will review data quarterly of # of person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties (frequency may change with updated OARs)	that are updated at least every 90 days/quarterly and shared with all relevant parties (frequency may change with updated OARs)

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	Care plans will be updated as needed following IDT/Care Conferences.	strong and respected voice in decisions about their care and support services • APD/AAA will actively engage individuals in the design, and where applicable, implementation of their LTSS service plan, in coordination with CCO where relevant to health care treatment and care planning. • APD/AAA will contact CCOs when they have referrals for ICC or otherwise have identified gaps or concerns about health care needs of members with LTSS. 4. APD will track • Client Assessment Planning System (CAPS) assessment results		
DOMAIN 4: Transitional care practices				
DOMAIN 4: Transitional care practices Goals	1. CCO CM will attend scheduled collaborative discharge IDT planning meetings to evaluate member's activity and progress and conduct concurrent reviews as appropriate for changing levels of care.	1. APD Diversion Transition Coordinators follow consumers for 90 days after Diversion or Transition unless consumer declines the service. 2. APD's Case Managers and Diversion Transition Workers will work together with the consumer	*1.CHA will review data quarterly on number of discharge assessments completed, to determine what resources were obtained by member prior to discharge and what obstacles*	% transitions where CCO communicated about discharge planning with APD/AAA office prior to discharge/transition? % transitions where discharge orders (DME, medications, transportation) were arranged

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	2. *CCO CM will collaborate with APD/DDS and other partners to promote successful transition from one level of care to the next. This will include completing discharge from current LOC. CHA CM will collaborate with APD Diversion Team and member to assure that member has copy of discharge summary, prescriptions, follow up orders, transportation and any needed DME for safe discharge to next level of care.* 3. CCO CM will enroll high risk CHA and DSNP members who are LTSS recipients in the CHA TOC Program where members are engaged and contacted weekly for 30 days post discharge from inpatient facility. 4. APD and CHA have a mutual understanding to avoid NOMNC/NOAs notice delivery the day before weekend begins. *CHA will initiate a cadence of quarterly debrief meetings between TOC CM and APD Diversion Team members to discuss transitions that were not*	to determine activities of daily living eligibility, member preferences, goals and assess for risks and barriers. 3. APD will provide education and training to CHA Case Managers as APD processes change and are updated. *4. APD will provider CHA Manager of Clinical Ops updated contacted list of Diversion Coordinators.* 5. APD and CHA will have a mutual understanding to avoid notice delivery of NOMNC/NOA's the day before weekend begins for both CCO and DSNP members. 6. Bi-weekly staffing between APD, SNF and CHA in which both will disclose essential medical and social needs to identify risk and assist in planning. 7. APD's Diversion Transition Workers receives referrals to assist consumers who need to transition from hospital or nursing facility. Diversion Transition Workers provide information on different care settings (from hospital to home, hospital to SNF, adult foster	*prevented a smooth transition of care.* *2.CHA will track information on number of members transitioning from one CCO to another and review qualitative data on those members to indicate appropriate APD/AAA office was notified.*	prior to discharge/did not delay discharge? % CCO region to CCO region transfers that communication was made to appropriate APD/AAA office(s)? # of Debrief meetings held quarterly to post-conference transitions where transition wasn't smooth (improvement process approach)? [Q1, Q2, Q3, Q4]

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	smooth, to promote process improvement.	home to assisted living etc.) and the process for the transition. Diversions and transitions are Monday through Friday. Any diversions or transitions that happen on the weekend are done by hospital or nursing facility staff unless details planned prior to the weekend. 10. APD/CCO meetings scheduled twice a month provide a clear communication venue for prescreening admissions and effective transition planning to enhance continuity of care for high risk members.		
DOMAIN 5: Collaborative Communication tools and processes				
DOMAIN 5: Collaborative Communication tools and processes Goals	• Each organization will share processes for communication, especially for ensuring referrals, IDT team meetings, care planning, or care transitions and identify key contacts for receiving communications (address all domains) • Each organization will share how they currently use Collective platform information and any specific ways they might use it, i.e. reports or other care planning or coordination processes. • Each organization will look to relationship of this information to assist building communication or processes in other domain areas	• Each organization will share processes for communication, especially for ensuring referrals, IDT team meetings, care planning, or care transitions and identify key contacts for receiving communications (address all domains) • Each organization will share how they currently use PointClickCare platform information and any specific ways they might use it, i.e. reports or other care planning or coordination processes. • Each organization will look to relationship of this information to assist building communication or processes in other domain areas.		# of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments # of CCO Collective Platform SNF notifications monthly that result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments MOU includes written process documents (prioritization, IDT, care planning, transitions) that

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				clearly designate leads from each agency for ensuring communication for roles and responsibilities for key activities and is shared and updated as needed (such as when lead contacts change).
OPTIONAL DOMAIN A: Linking to Supportive Resources				
OPTIONAL DOMAIN A: Linking to Supportive Resources Goals	*CHA offers NEMT through Translink* *CHA offers Flex Fund and Health Related Spending benefits for CHA and DSNP members to cover items excluded by insurance.* *CHA has a Benevolence Fund for review of high spend interventions excluded from insurance benefit.* *CHA will present information on supportive benefits provided to CHA and DSNP members at least annually APD staff; will present on new support programs as they are developed.*	In scheduled collaborative meetings, phone calls and emails: --Each organization will share types of programs and resources and process for qualifying/accessing services. --Each organization will share how supportive resources assist building communication or processes in other domain areas. --Educate consumers about how the CCO and AAA/APD work together to ensure that they can navigate the system and understand what is provided by the CCO and what is provide by AAA/APD.		

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OPTIONAL DOMAIN B: Health Promotion and Prevention				
OPTIONAL DOMAIN B: Safeguards for Members Goals	--CCOs shares process for access to health promotion and prevention activities and services available through the CCO. Share resources for members with LTSS in local communities, including access to culturally-specific programs where available. --CCO will share process by which CCO considers Health Related Services Requests for health and wellness activities (formerly flexible services, see glossary). --CCO shares new tracking systems for navigation and referrals to community resources for social determinants of health or how members can access services from THWs. --CCO will discuss opportunities to connect members to health promotion and wellness activities and services offered through APD/AAA			
OPTIONAL DOMAIN C: Safeguards for Members				

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OPTIONAL DOMAIN C: Cross-System Learning Goals	--Each organization will share process for identifying needed safeguards. --Each organization will look to relationship of this information to assist building communication or processes in other domain areas. --Incorporation of safeguards and methods of sharing resources with members into MOUs --Identify potential unique needs for subpopulations of beneficiaries with LTSS and how cross-system MOUs can create additional opportunity to ensure safeguards for members	--Each organization will share process for identifying needed safeguards. --Each organization will look to relationship of this information to assist building communication or processes in other domain areas. --Incorporation of safeguards and methods of sharing resources with members into MOUs --Identify potential unique needs for subpopulations of beneficiaries with LTSS and how cross-system MOUs can create additional opportunity to ensure safeguards for members		

SIGNATURES: Include Name, Job Title, Agency, Signature, Date

Signatures of All MOU parties (APD/AAA and CCO) should be included and signed prior to December 31st. OHA/DHS review will occur after CCO submits the MOU. Neither OHA or DHS will require review or co-signature to the MOU.

CCO Authorized Signature: DocuSigned by: Arthur Petersen C99F4D2210E94F8...

Name: Arthur Petersen

Title: Director of Clinical Operations

Date: 1/30/2024

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APD / AAA Field Office Authorized Signature:

Name: Gloria Pena DocuSigned by: Gloria Pena A98F195EC6FF476...

Title: APD District Manager, District 11 Klamath/Lake Counties

Date: 1/30/2024

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☐ **APD notification ONLY**
☐ **IDT referral**

Cascade Health Alliance

Inter-Disciplinary Team (IDT) Referral Form

This referral form is for difficult cases that require additional input and resources. This referral form is designed to reach CHA/BH Case and Utilization Review Manager, Case Management, Aging & People with Disabilities (APD) in order to collaborate together to meet the needs of Complex CHA CCO Members.

Member Information:					
Member Name:		County of Residence:	KLAMATH	Date of Referral:	
ID/Prime#:		DOB:			

Status:			
Current Location/Placement:			
If member is at a Skilled Nursing Facility fill this line in	Admission Date:	Approved thru:	20th day:
Anticipated Placement:			
Reason for Referral:			
Notes:			

Contact Info:			
Is member aware of referral?		Phone# of member	
Person completing this form:		Phone# of referring person for questions.	

Note: If you have any questions regarding the referral process please call 541-883-2947 for assistance.

CULTURAL COMPETENCY POLICY AND PROCEDURE

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

CONTENTS

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

- This policy and procedure establishes and delineates responsibilities for providing culturally competent care for our members, including the needs of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex (including pregnancy), sexual orientation, gender identity, age, physical or mental disability, or veteran status.

2 SCOPE

2.1 This policy and procedure applies to all employees and contracted providers and their staff.

2.2 This policy outlines the requirements of our organization to provide culturally competent care within our offices and our responsibility to ensure our contracted providers are trained in cultural competence.

3 POLICY STATEMENT

3.1 We are committed to providing all members culturally competent care. We strive to provide equal opportunity to members for obtaining care that recognizes their experiences, cultural diversity, and needs, including those members of all protected classes: race, ethnicity, color, National origin, citizenship, religion, sex, sexual orientation, gender, gender identity, age, physical or mental disability, or veteran status .

3.2 We follow the requirements for trainings provided to employees, contracted providers and their staff as outlined by the Oregon Health Authority's Office of Equity and Inclusion and House Bill 2611 (2013).

4 PROCEDURE

Confidentiality Statement
This Cultural Competency Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

4.1 We strive to reflect the cultural diversity of Klamath County.

4.2 We cover the cost for telephonic translation for all providers and members and encourage provider organizations to staff multi-lingual employees.

4.2.1 Providers are provided directions for using interpreter services in the annual in-person provider training session and in the provider manual.

4.2.2 Providers who many not already have interpreter services are directed to use the ATT Linguava to access interpreters for over 140 languages.

4.3 Providers and their staff attend in-person provider training hosted annually. This training addresses the importance of cultural competency and the services we offer to help providers communicate more effectively with their patients.

4.3.1 Provider training also addresses the importance of signage and written communication in the members' native languages.

4.4 Important member informational literature is available in Spanish and in large print on the website. Our website can also be translated into 21 additional languages by selecting a different language from the drop-down menu at the bottom of our webpage.

4.4.1 Other informational literature includes taglines in other languages for members to contact Member Services for further assistance.

4.4.2 All correspondence with members is written in plain language, to a sixth-grade reading level.

5 RESPONSIBILITIES

5.1 The Provider Network Manager will:

5.1.1 Execute annual training for providers on cultural competency.

5.2 The Director of Health Equity and Quality Management will:

5.2.1 Ensure critical materials are translated into all prevalent member languages, as specified in our contract with OHA, including, but not limited to, the Member Handbook, Notice of Action, Notice of Appeal Resolution, Provider Directory, Privacy Notice, and Authorization for Release of Information.

5.3 All Department Directors will:

5.3.1 Ensure critical materials are available and flagged for translation and forwarded to the correct contact.

Compliance, Monitoring and Review

5.4 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.

Reporting

5.5 No additional reporting is required.

Records Management

Confidentiality Statement
This Cultural Competency Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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

6 DEFINITIONS

Terms and Definitions

6.1 **Cultural Competence:** the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities, and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. (OHA Contract # 143110-11)

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Cultural Competence Continuing Education (CCCE) – HB 2611

7.2 Oregon Administrative Rule (OAR) 943-090-0000 through 943-090-0020

7.3 OHA Contract # 143110-11

7.4 OHA Office of Equity and Inclusion CCCE Criteria for Approval (CAO December 2017)

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	10/12/2018, 10/8/2019
Approval Dates	10/15/2018, 10/8/2019

Confidentiality Statement
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CULTURAL RESPONSIVENESS and IMPLICIT BIAS EDUCATION AND TRAINING PLAN POLICY & PROCEDURE

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

CONTENTS

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.

CHA 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 (including pregnancy), sexual orientation, gender identity, age, physical or mental disability, and veteran status.

1 PURPOSE

1.1 This plan outlines the process for determining training needs for staff and providers to ensure that members receive services in a culturally and linguistically appropriate manner.

2 SCOPE

2.1 This plan applies to all CCC staff, Board of Directors, subcontractors and network providers.

3 POLICY STATEMENT

3.1 CCC staff, directors, subcontractors and network providers will treat members in a manner which is responsive to the member's culture, in the member's preferred language, and mindful that a member may have a trauma history and multiple adverse childhood experiences contributing to their current healthcare choices.

3.2 CCC's staff, subcontractors and providers are trained in integration, and Foundations of Trauma Informed Care and CCC provides regular, periodic oversight and technical assistance on those topics to providers.

Confidentiality Statement
This Cultural Competency and Responsiveness Training Plan, Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

3.3 CCC staff, subcontractors and providers of behavioral health services are trained in trauma-informed care, recovery principles, motivational interviewing; and CCC provides regular, periodic oversight and technical assistance on those topics to other providers as requested.

4 PROCEDURE

4.1 CCC provides annual and ongoing training to its staff, Board of Directors, subcontractors and network providers in accordance with the requirements contained in its contract with the Oregon Health Authority. These trainings include:

- 4.1.1 Implicit Bias
- 4.1.2 Cultural Responsiveness
- 4.1.3 Trauma Informed Care, including Adverse Childhood Experiences (ACEs)
- 4.1.4 CLAS Standards and the use of REAL+D data to advance Health Equity
- 4.1.5 ADA compliance, universal access and accessibility
- 4.1.6 Language Access
- 4.1.7 Health Literacy
- 4.1.8 Foundations of Peer Delivered Services
- 4.1.9 Integration
- 4.1.10 Recovery Principles

Staff Trainings

4.2 All new staff are oriented to CCC's policies and procedures related to Cultural Competency and Responsiveness, Implicit Bias, and Language Access upon hire, and at least annually thereafter.

4.3 Training topics and content are prioritized based on feedback received during focus groups held pursuant to the Health Equity Assessment, staff surveys, and the Community Advisory Council.

4.4 Trainings will be facilitated through multiple mediums, including staff meetings, online courses, "lunch and learns", or more formal trainings facilitated by an external trainer.

4.5 The Director of Health Equity and Quality Management will maintain a registry of trainings and attendees.

- 4.5.1 Consistent patterns of non-attendance by staff members will be referred to the staff member's immediate supervisor for corrective action.

Provider Trainings

4.6 Providers and their office staff are expected to be current with cultural responsiveness and/or competency training.

- 4.6.1 Providers attest to current training in cultural responsiveness/competency at the time of credentialing and re-credentialing.
- 4.6.2 CCC maintains providers' cultural competency policies and procedures as part of the credentialing file.

4.7 Linguava access and instructions for use are given to each provider upon entry into CCC's network.

4.8 In-person provider trainings are held annually, or more frequently as necessary, for providers and their office staff. Annual training will include:

- 4.8.1 Fraud, Waste and Abuse policies and procedures
- 4.8.2 Credentialing policies and procedures
- 4.8.3 Cultural Responsiveness and Implicit Bias

Confidentiality Statement
This Cultural Competency and Responsiveness Training Plan, Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

4.9 Providers who do not attend annual training in Cultural Responsiveness and Implicit Bias must attest to having completed this training independently of that provided by CCC.

4.10 Supplemental training topics and content are prioritized based on feedback received during focus groups held pursuant to the Health Equity Assessment, and feedback received from the Community Advisory Council.

4.11 The Director of Health Equity and Quality Management maintains a registry of trainings and provider/staff attendees as it pertains to trainings related to any of the mandated trainings as noted above.

4.11.1 Consistent patterns of non-attendance at provider trainings will be referred to the Provider Network Manager for discussion, up to and including corrective action if necessary.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The Director of Health Equity and Quality Management is responsible for:

5.1.1 Facilitating the annual Health Equity Assessment, and prioritizing training needs as identified through the assessment process.

5.1.2 Maintaining the training registry for staff and providers.

5.1.3 Identifying performance metrics and measurable outcomes to measure the success of the implementation of this plan in improving the culturally responsive provision of services to members by staff and providers.

5.1.3.1 Metrics will be reported and trended quarterly in the Equity dashboard.

5.1.3.2 Providers not performing at target or benchmark will be referred to the Provider Network Manager for discussion, up to and including corrective action if necessary.

5.1.4 Development and internal distribution of the quarterly Population Health Dashboard.

5.1.5 The development of the Health Equity Plan, which includes the Cultural Responsiveness and Implicit Bias Training and Education Plan, including the submission to the Oregon Health Authority (OHA) of the Annual Health Equity Assessment Report.

5.1.6 The development and submission to OHA of the Annual Training and Education Report.

5.1.7 The development and submission to OHA of the Language Access Plan and quarterly reports.

5.2 The Compliance department is responsible for maintaining all credentialing files, including records of provider cultural competency and responsiveness training and related policies and procedures.

5.3 The Provider Network staff is responsible for managing providers who are not compliant with cultural competency and responsiveness training attendance and/or attestation of such training.

5.4 The Compliance Officer is responsible for managing members of the Board of Directors who are not compliant with attendance at trainings on cultural responsiveness and implicit bias, and other required topics as noted in this plan.

5.5 The Health Equity and Quality department is responsible for monitoring performance to identify additional improvement opportunities.

5.6 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.

Reporting

Confidentiality Statement
This Cultural Competency and Responsiveness Training Plan, Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

5.7 The population health Dashboard is reported quarterly to all CCC departments.

Records Management

5.8 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 **Cultural Competence:** the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families and communities, and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. (OHA Contract # 143110-11)

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Alternate Format and Language Access Services.PP13002

7.2 CLAS Roadmap

7.3 Criteria for Approval Cultural Competence Continuing Education Training; Oregon Health Authority, Office of Equity and Inclusion, December 2017

7.4 Cultural Competency Training Plan Roadmap

7.5 Health Equity Policy and Procedure.PP09009

7.6 Health Equity Roadmap

7.7 Oregon Administrative Rule: OAR 943-090-0000 through 943-090-0020

7.8 Provision of Culturally and Linguistically Appropriateness Policy and Procedure.PP13003

7.9 *https://traumainformedoregon.org/tic-intro-training-modules/*

7.10 *Trauma Informed Care Roadmap*

7.11 Health Insurance Portability and Accountability Act (HIPAA)

7.12 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	Executive Approval Committee
Committee Review Dates	01/09/2020
Approval Dates	01/09/2020

Confidentiality Statement
This Cultural Competency and Responsiveness Training Plan, Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

HEALTH EQUITY POLICY AND PROCEDURE

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

CONTENTS

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 CHA's policy to ensure that all CHA strategies, plans, policies, and processes are reflective of the unique needs of all members and include steps to ensure health equity.

2 SCOPE

2.1 This policy applies to all CHA staff, CHA documents and processes, as well as CHA participation in external community committees.

3 POLICY STATEMENT

3.1 CHA is committed to meeting the needs of all members regardless of race, ethnicity, color, National Origin, citizenship, age, physical or mental disability, gender, gender identity, sex, sexual orientation, religious affiliation, or veteran status.

3.2 CHA strategies, plans, policies, and processes will be written through the lens of health equity to ensure that members' needs are met, including the provision of external resources if internal resources are unavailable to meet the needs of the member.

3.3 Achieving health equity requires the equitable distribution of resources and power resulting in the elimination of gaps in health outcomes between different social groups.

3.4 CHA will work with community partners and other stakeholders to look for solutions to health disparities outside of the health care system to improve the health of our community as a whole.

4 PROCEDURE

4.1 Health Equity Lens means the following items must be considered in the development of all strategies, plans, policies, and processes:

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4.1.1 Will all members have equitable access to the services addressed in the strategy, plan, policy or process?

4.1.2 Does the strategy, plan, policy, or process include provision for languages other than English?

4.1.3 Does the strategy, plan, policy, or process include provision for alternative formats, for example, large print, audio, braille, sign language, etc.?

4.1.4 Does the strategy, plan, policy or process adequately account for members' cultural needs?

4.1.5 Is the strategy, plan, policy or process trauma-informed, and does not inadvertently contribute additional trauma to members?

4.1.6 Does the strategy, plan, policy or process have the potential to inadvertently create, contribute to, or support decisions, local policies, investments, rules or laws that contribute to health inequities?

4.1.7 Was member voice included in the development of the strategy, plan, policy, or process?

4.1.8 Does the staff team need additional training to ensure that the strategy, plan, policy or process can be successfully executed without inadvertently creating health disparities or barriers to members?

4.2 Staff participating in external committees will ensure that decisions or recommendations made by the committee will not create or contribute to health inequities by applying the questions outlined above.

4.3 CHA will maintain a Health Equity (HE) Plan, based on a community-wide health equity assessment, which outlines CHA's strategy for assisting its members and the community in achieving the highest level of health possible, and working toward reducing and eliminating health disparities in our community.

4.3.1 Strategic priorities will be in alignment with the Community Health Improvement Plan as approved by the Community Advisory Council as well as by the State Health Improvement Plan.

4.3.2 Member, staff, and provider focus groups will be held periodically to gauge CHA's progress in achieving the goals of the HE Plan.

4.3.3 Interventions will be determined based on feedback received during focus groups and informed by data specific to Klamath County and CHA membership.

4.3.4 Performance metrics and outcome measures will be determined based on interventions and will be designed to measure CHA's success in executing the HE Plan.

4.3.5 Community-wide interventions will be determined following the processes and procedures outlined in the *Health-Related Services Policy and Procedure.PP09008*, which includes the provisions included in the *Community Projects Advisory Committee Charter* and *Request for Grant Proposals*.

4.4 CHA will facilitate Health Equity trainings for its staff, providers, and Board of Directors based on feedback provided through the focus group process, Klamath County data indicating areas of need, and evidence-based research on emerging topics in the field.

4.4.1 The Quality Management department will maintain a training log of all trainings held and attendees.

4.4.2 Consistent patterns of non-attendance by staff members at trainings will be referred to the staff member's immediate supervisor for corrective action.

4.4.3 Consistent patterns of non-compliance by providers at trainings will be referred to the Provider Network Manager for discussion and further follow-up, including corrective action if necessary.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

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5.1 Each Department Head and/or Director is responsible for ensuring that all strategies, plans, policies, and procedures are written and reviewed against the questions outlined above, and revisions made as necessary to ensure equity.

5.2 The Health Equity Manager will:

5.2.1 Provide technical assistance upon request to ensure health equity is considered in all CHA activities and documentation.

5.2.2 Ensure training of the staff team to promote, educate, advocate, and ensure health equity for all CHA members per the Cultural Competency Training Plan.

5.2.3 Maintain a training registry of all health equity trainings by staff member and department.

5.2.4 Work in collaboration with Business Intelligence and Decision Support to ensure that performance metrics are stratified by indicators of health equity.

5.2.5 Identify both internal and external improvement opportunities as they pertain to health equity, including the identification of interventions and measurable outcomes.

5.2.6 Create and publish CHA's Equity Dashboard quarterly.

5.2.7 Submit Language Access Services Report to OHA quarterly.

5.3 The Director of Quality Management serves as the Single Point of Accountability for Health Equity for CHA, and will:

5.3.1 Ensure the integrity of CHA's Heath Equity Policy and all related activities

5.3.2 Review strategies, plans, policies, and processes against the questions outlined above as requested.

5.3.3 Promote health equity both internally and externally within the community.

5.3.4 Develop and monitor the execution of the HE Plan.

5.4 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.

Reporting

5.5 No additional reporting is required.

Records Management

5.6 All records pertaining to the execution of this policy, including the Health Equity Training Log, will be kept by the Quality Management Department.

6 DEFINITIONS

Terms and Definitions

6.1 **Health Disparities:** Health disparities are differences in population health status that are avoidable and can be changed. These differences can result from environmental, social and/or economic conditions, as well as public policy. These and other factors adversely affect population health. Health disparities are referred to as health inequities when they are the result of the systematic and unjust distribution of these critical conditions

6.2 **Health Equity:** The attainment of the highest level of health for all people; the absence of unfair, avoidable, or remediable differences in health among social groups. Health equity implies that health should not be

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compromised or disadvantaged because of racism, classism, sexual discrimination, religious discrimination, linguistic discrimination, nationalism, ableism, or by neighborhood or other social condition.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 *Alternate Format and Language Access Services.PP13002*

7.2 CHA Request for Grant Proposals

7.3 Community Projects Advisory Committee (CPAC) Charter

7.4 CLAS Roadmap

7.5 Cultural Competency Roadmap

7.6 Exhibit A for RFGP 2020

7.7 *Flexible Funds Policy and Procedure PP06008*

7.8 Health Equity Roadmap

7.9 Health-Related Services Guidance Document, Oregon Health Authority Health Policy and Analytics Division Office of Health Policy, July 2018

7.10 Using Health-Related Services to Address Housing Needs: A Guide for Oregon CCOs; Oregon Health Authority, August 2019

7.11 Health-Related Services Roadmap

7.12 Health Insurance Portability and Accountability Act (HIPAA)

7.13 Language Access Plan Roadmap

7.14 Oregon Administrative Rule: OAR 943-090-0000 through 943-090-0020

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

7.16 Oregon Health Authority Social Determinants of Health and Health Equity Guidance Document

7.17 *Provision of Culturally and Linguistically Appropriateness Policy and Procedure PP13003*

7.18 *SDOH Health Equity Priorities Spending PP11005*

7.19 Trauma Informed Care Roadmap

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	10/30/2019
Approval Dates	10/31/2019

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INTERPRETER QUALITY MONITORING PROCESS

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

1 PURPOSE

1.1 To ensure CHA's Language Access Services Partner (LASP) maintains rigorous hiring, screening and training program(s) to ensure only certified and/or qualified interpreters are used for CHA members.

1.2 To ensure the LASP retains a comprehensive Professional Liability Insurance Policy including wrongful acts.

1.3 To establish standards for monitoring the use of certified and/or qualified interpreters for member services and address non-compliance of language access services.

2 SCOPE

2.1 This process applies to the Member Experience Committee (MXC) and the Member Services and Compliance departments involved in ensuring the interpreter quality provided by LASP.

3 PROCESS

3.1 Reference *Alternate Format and Language Access Services PP13002* for process to ensure appropriate language access service are available for members.

3.2 An annual audit will be conducted by the Director of Member Services, or delegate, to ensure only qualified interpreters are used to assist members.

3.2.1 Professional Liability Insurance Policy

3.2.1.1 LASP will supply a current Confirmation of Coverage for their Professional Liability Insurance Policy to the Director of Member Services annually.

3.2.2 Audit for Qualified Interpreters:

3.2.2.1 LASP will submit a report with the names of all interpreters' who assisted members the prior 12 months.

3.2.2.2 The Director of Member Services will randomly select the lesser of 10% or 10 interpreters to sample.

3.2.2.3 The Director of Member Services will request and evaluate the following screening and/or results for each of the randomly selected interpreters:

3.2.2.3.1 Copy of relevant certification if available (required for American Sign Language interpreters), or

3.2.2.3.2 Copy of Language Proficiency Screening results (English and target language), or

3.2.2.3.3 Copy of Interpreters Skills Assessment Test (or equivalent) results, and

3.2.2.3.4 Copy of results from any interpretation services related assessments or trainings completed within prior 12 months through LASP's ongoing training program

3.3 Analysis and Monitoring:

3.3.1 Any language access related grievances captured by the Compliance Department are reported monthly to the MXC

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This Interpreter Quality Monitoring Process Provider Monitoring Process along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

3.3.2 For the annual audit, the Director of Member Services, or delegate shall review submitted documents and:

3.3.2.1 Confirm dates are current on the Confirmation of Coverage for the LASP's Professional Liability Insurance Policy

3.3.2.2 Verify interpreters' certification(s) are current (if required)

3.3.2.3 Evaluate results from each interpreters' screenings, assessments and tests to ensure acceptable scoring of at least 85% accuracy was achieved.

3.3.2.3.1 If outliers and/or concerns are identified, the Director of Member Services presents in the next monthly MXC meeting, or to the Compliance Officer (CO) immediately if an urgent concern is identified.

3.3.2.4 The MXC and/or CO conducts further analysis of reporting and/or audit documentation and determines the course of action.

3.4 Member Experience:

3.4.1 At the direction of the MXC and/or CO, the Director of Member Services, or delegate, conducts initial outreach to the LASP to communicate concerns.

3.4.1.1 CHA and LASP develop necessary corrective action plan to address all identified concerns.

3.4.1.2 Reference Corrective Action Plan Template Appendix *PP13002*.04

3.4.1.2.1 Progress is documented and monitored via the corrective action plan in place until closed or additional action is required, which may include, but not limited to, termination of LASP contract.

3.4.1.3 Status is presented monthly to the MXC and/or CO.

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This Interpreter Quality Monitoring Process Provider Monitoring Process along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

INTERPRETIVE SERVICES POLICY AND PROCEDURE

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

CONTENTS

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1 PURPOSE

1.1 To provide members with high quality language support by ensuring employees and contracted providers communicate with members in their preferred language at all touch points within their daily business routines.

1.2 To ensure members receive clear, concise and accurate information about their health.

2 SCOPE

2.1 This policy applies to all team members and the availability of interpretive services.

3 POLICY STATEMENT

3.1 To make interpretive services (for all non-English languages) available free of charge and inform all members that oral interpretation is available for any language and written translation is available in prevalent languages,

3.1.1 This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.

3.1.2 CHA notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities via the member handbook and on the website.

3.2 Communication to members in their preferred language prevents miscommunication regarding diagnosis and treatment. And assure no barrier to a member care or health outcomes occur due to language incompatibility.

4 PROCEDURE

Confidentiality Statement
This Interpretive Services Policy and Procedure along with all attachments hereto shall be considered.
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4.1 Language assistance is clearly outlined in the *Enrollee Rights and Responsibilities PP13001.01*. Each member receives this list of enrollee rights and responsibilities within their member handbook at time of enrollment.

4.2 Important member informational literature is available on our website. The website is available in multiple languages.

4.3 Member materials are translated and formatted to accommodate members' needs, including both audio and large print.

4.4 Signage is provided in the most commonly used languages of the member population.

4.5 The Customer Services Department includes team members who are proficient in English and Spanish which addresses the language for the majority of the member population.

4.6 All correspondence with members is written to a sixth-grade reading level.

Accessing the Language Line

4.7 The Language Line is used to assist team members and providers to communicate effectively to members who have either limited English proficiency, who are deaf and/or hard-of-hearing.

4.8 The Language Line must be accessed at any touch point where an employee or provider is not able to communicate with a member at the highest quality and does not provide or have access to onsite staff to communicate with a member in their preferred language.

4.9 The Language Line offers interpreters for various languages.

4.10 Language Line interpreters undergo rigorous screening, testing, and training, including learning specialized medical terminology and procedures to ensure clear, concise, and accurate communication during each encounter.

Placing an outbound call to a limited English proficiency, deaf and/or hard-of-hearing member:

4.11 Dial 1 (800)774-4344.

4.12 Enter the 6-digit client ID: 242053.

4.13 Press 1 for Spanish or 2 for all other languages (speak the name of language when prompted), an interpreter will be connected to the line.

4.14 Interpreter will ask for a DMAP number: 135843.

4.15 Brief the interpreter as the nature of the call and provide him/her with member phone number.

4.16 The interpreter will connect the call.

Receiving an inbound call by a member with limited English proficiency, deaf and/or hard-of-hearing:

4.17 Use the conference line to place the member on hold.

4.18 Pick up a new phone line.

4.19 Dial 1(800)774-4344

4.20 Enter the 6-digit Client ID: 242053

4.21 Press 1 for Spanish or 2 for all other languages (speak the name of language when prompted); an interpreter will be connected to the line.

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4.22 Interpreter will ask for a DMAP number: 135843.

4.23 Brief the interpreter if possible and summarize what you wish to accomplish on the call.

4.24 Press the conference button twice to connect all parties.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The Compliance Department conducts an annual quality audit to monitor and assess multi-lingual staff resources, use, and training on Language Line services.

5.2 Language Line grievances will be monitored through Compliance and reported to Director of Customer Service.

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.

Reporting

5.4 No additional reporting is required.

Records Management

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

6 DEFINITIONS

7 RELATED LEGISLATION AND DOCUMENTS

7.1 The Coalition of Communities of Color

7.2 Code of Federal Regulations

7.3 *Enrollee Rights and Responsibilities PP1300.01*

7.4 Oregon Administrative Rule (OAR) 943-090-0010

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

7.6 OHA Contract

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	04/10/2019, 07/02/2019, 07/31/2019
Approval Dates	04/18/2019, 07/26/2019, 08/01/2019

Confidentiality Statement
This Interpretive Services Policy and Procedure along with all attachments hereto shall be considered.
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SOCIAL DETERMINANTS OF HEALTH (SDOH): SOCIAL NEEDS SCREENING AND REFERRAL TRAINING POLICY AND PROCEDURE

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

CONTENTS

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1 PURPOSE

1.1 This policy and procedure establish a comprehensive and consistent framework for the Social Determinants of Health (SDOH) screening and referral training to the appropriate channels for unmet social needs.

2 SCOPE

2.1 This policy applies to CCC/CHA Health Equity, Case Management, Member Services departments, and network providers.

3 POLICY STATEMENT

3.1 Select a comprehensive SDOH Assessment tool, in accordance with Oregon Health Authority (OHA) Coordinated Care Organizations (CCOs) Metrics Technical Advisory Group (TAG), to utilize an approved or exempted screening tool to assist member social needs.

3.1.1 Screening tool needs to align with national social needs screening measures and have a range of available languages.

3.1.2 Screening tool must include housing, food and/or transportation questions.

3.1.3 Screening tool needs to have capacity to streamline administrative process to better member care coordination.

3.2 Screening tools must be revised yearly in order to be in compliance with OHA rules and regulations.

3.3 Screening tools shall be preloaded into current Electronic Health Record (EHR) or Electronic Medical Record (EMR) to provide better member healthcare.

3.4 Screening tools may be preloaded into a member portal for members to complete the assessment at their convenience.

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3.4.1 Member provided answers can be injected into current EHR/EMR member profile, to gather documentation and provide better member care.

3.5 Screening and referral training falls under the jurisdiction of the CCO health equity department but is not limited to it.

3.6 Screening and referral training shall include CCO staff and partners – including contractors, in-network providers, and CBO partners. Provide access to written protocols and best practices for assessing member's unmet social needs.

4 PROCEDURE

4.1 Screening and referral trainings will be provided by the CCO health equity through electronic/online training modules, presentations, classroom formats, and structured coaching and mentoring.

4.1.1 Patient engagement, empathic inquiry and motivational interviewing, trauma-informed practices, cultural responsiveness, and equitable practices topics must be included.

4.1.2 CCO members may decline to be screened or to accept referrals at any time.

4.2 Screening and referral training must include an online training program with provided link for assessing members' unmet social needs.

4.3 CCO will utilize OHA-approved social needs screen tool "Protocol for responding to and assessing patients' assets, risks and experiences" better known as PRAPARE in collaboration with a community information exchange database for members social needs.

4.3.1 PRAPARE includes sections such as food insecurity, housing insecurity and transportation needs.

4.4 CCO staff and partners – including contractors, in-network providers, and CBO partners have agreed that over-screening could be retraumatizing to members; however, member situations and or environments can change at any given point. Therefore, allowing members to verify if assessment has been completed and/or accurate to determine if new events could affect their social determinants of health.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 The CCO Health Equity department shall be monitoring and reviewing the data results from this tool. By gathering and analyzing the demographics data, they may bring forth suggestions with hard evidence to respective advisory committee.

5.2 The Community Advisory Committee (CAC) will review this policy and procedure for compliance with OHA contract and guidelines at least once a year, or as applicable.

Reporting

5.3 Any additional reporting is subject to approval by the Director of Health Equity and Quality Improvement.

Records Management

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

6 RELATED LEGISLATION AND DOCUMENTS

6.1 Social Determinants of Health: Social Needs Screening and Referral Measure

6.2 Oregon Health Authority : Social needs screening tools : Transformation Center : State of Oregon

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

7 FEEDBACK

Confidentiality Statement
This SDOH Social Needs Screening and Referral Training Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

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

8 APPROVAL AND REVIEW DETAILS

Approval and Review	Details
Advisory Committee to Approval	
Committee Review Dates	
Approval Dates	

9 APPENDIX

9.1 SDOH Social Needs Screening and Referral Training Policy and Procedure (PP15006.01)

Confidentiality Statement
This SDOH Social Needs Screening and Referral Training Policy and Procedure along with all attachments hereto shall be considered Cascade Comprehensive Care's (CCC) Proprietary/Confidential Information

DEMOGRAPHIC REVIEW POLICY AND PROCEDURE

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CONTENTS

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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, age, physical or mental disability, and veteran status.

1 PURPOSE

1.1 This policy establishes a framework for how CCC reviews aggregated member data to ensure that potential inequities tied to member demographics are explored and addressed.

2 SCOPE

2.1 This policy applies to any instance where CCC member data is under review including financials, performance metrics, population health statistics, disease prevalence, and when identifying priority populations for addressing Social Determinants of Health (SDoH) needs. This policy applies to all departments that utilize aggregated CCC member data on members or member activity.

3 POLICY STATEMENT

3.1 Regardless of format, review of aggregated CCC member data must include analysis to show how that data applies to members of the following disaggregated demographic categories (if such categories can be reasonably applied to the data being explored or presented):

3.1.1 Age

3.1.2 Race/Ethnicity

3.1.3 Language

3.1.4 Disability

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3.1.5 Sexual Orientation

3.1.6 Gender Identity

3.2 This application of policy will be referred to as 'Demographic Review'.

3.3 When Demographic Review identifies a potential disparity, it is referred to the Health Equity & Quality department for validation and possible action.

3.4 Validated disparities are tracked to help inform decision-making processes and reviewed for improvement whenever an action is taken in support of improving a disparity.

4 PROCEDURE

4.1 Demographic Review

4.1.1 Demographic Review involves taking aggregated member information and breaking it up to show how various demographic attributes change or affect the data being explored.

4.1.1.1 If an aggregated report shows metric performance over a period of time, the Demographic Review for the *Age* category will show performance for members in one or more age ranges over the same time period.

4.1.1.2 If an aggregated report shows the cost of emergency services provided for a particular diagnosis, the Demographic Review for the *Language* category will show the proportion of those emergency service costs attributed to members based on their spoken or written language preferences.

4.1.2 Suppressing Small Numbers

4.1.2.1 Demographic Review may result in exploring data for small populations that, if shared openly, would allow individual members to be identified in the data under review. The following steps must be taken to limit small group exposure.

4.1.2.2 Denominator Exclusion – Groups with small populations (Denominator less than 50 members, 600 member months, 50 member years, or 250 inpatient stays) can be removed from the reporting details to protect member anonymity.

4.1.2.2.1 The following language to inform of the member-level suppression must be included**: "To protect confidentiality, we do not show communities with fewer than 50 eligible members."**

4.1.2.2.2 The following language to inform of the member-months suppression must be included**: "To protect confidentiality, we do not show communities with fewer than 600 eligible member months."**

4.1.2.2.3 The following language to inform of the member-years suppression must be included**: "To protect confidentiality, we do not show communities with fewer than 50 eligible member years."**

4.1.2.2.4 The following language to inform of the inpatient stay suppression must be included**: "To protect confidentiality, we do not show communities with fewer than 250 eligible inpatient stays."**

4.1.2.3 Numerator Suppression – Groups that meet the denominator reporting threshold of 50+ members but whose numerator is a very small number (5 or less members, 25 or less

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inpatient stays) can be referenced by falling into a range that includes their actual data but in a way that makes the specifics unknown.

4.1.2.3.1 The following language to inform of the member-level suppression must be included: **"To protect confidentiality, member numerator counts of five or less are suppressed and published as "1-5". Numerator counts of greater than five are published as the number. Demographic categories with no numerators are published as zero."**

4.1.2.3.2 The following language to inform of the inpatient stay suppression must be included: **"To protect confidentiality, inpatient stay numerator counts of twenty-five or less are suppressed and published as "1-25". Numerator counts of greater than twenty-five are published as the number. Demographic categories with no numerators are published as zero."**

4.1.2.4 Suppression for Internal Review vs External Review – When sharing data internally that would normally be suppressed if shared externally, indication that data is for internal use only must be provided, and any data that must be suppressed if shared externally should be highlighted.

4.1.2.4.1 All numerators and denominators in the Demographic Review that meet the categories listed above must be marked with an asterisk (*) and the following language included prominently in the presentation: **"* - This data is confidential and must be suppressed if shared externally. Please review the *Demographic Review Policy and Procedure* for rules on how to suppress confidential demographic data prior to sharing externally."**

4.2 Recognizing Inequity

4.2.1 Significant differences between baseline performance and the performances shown in Demographic Review can indicate a possible inequity. There are no specific thresholds for performance deviation that signify a possible inequity as margins for variance vary greatly from one performance measurement to another. The person or group performing Demographic Review should make informed decisions about inequity identification based on experience.

4.3 Taking Action to Correct Inequities

4.3.1 Investigation by the HEQ Department will be made when a possible inequity is identified.

4.3.2 The person or group performing the Demographic Review that identified the possible inequity should e-mail the details of the findings to the HEQ Director.

4.3.3 The HEQ Department will validate the findings and, if determined to truly be an inequitable situation, log it as such in a disparity tracker used to inform Health Equity project work.

4.4 Demographic Review Disparity Tracker

4.4.1 The tracker will contain at least the following details for each reported and confirmed inequity:

4.4.1.1 Affected Demographic, Performance Measurement Name, Baseline Performance (including Numerator and Denominator, if available), Demographic Performance, Measurement Timeframe, Date Added to Tracker, Recent Intervention Made, Date of Recent Review, Performance at Time of Review, Active/Resolved status.

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4.4.2 The Health Equity & Quality department uses the Disparity Tracker to help identify priority populations for interventions based on how frequently they appear on the tracker with reported potential inequities.

4.4.3 Populations identified through the demographic review process are prioritized for outreach, and Social Determinants of Health (SDoH) screening will be utilized for closed-loop referrals to services as needed.

4.4.4 Populations affected most by proposed changes to a process (as supported by the Disparity Tracker) are prioritized when implementing solutions.

4.4.5 Whenever a priority population becomes the focus for an intervention, this intervention is noted on the Disparity Tracker for any relevant performance measurement for that demographic. After the intervention has concluded, updated baseline performance and Demographic Review is logged in the tracker to identify progress towards eliminating inequities.

5 RESPONSIBILITIES

Compliance, Monitoring and Review

5.1 Policy Support and Requirements

5.1.1 This policy aligns with the Oregon Health Authority's goal of eliminating inequities by 2030.

5.1.2 This policy supports the need for written policies that use REALD data to inform work on social needs screening and referrals as required Attestation for the OHA incentive metric SDOH: Screening and Referral Measure (Section A.5).

5.2 The adherence to and monitoring of this policy and procedure may be included in the Compliance department's annual internal audit.

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.

Reporting

5.4 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:

5.4.1 Incentive Metric performance

5.4.2 MA Stars measures performance as reported by Atrio corporate

5.4.3 Claims

5.4.4 Electronic Health Record (EHR) data

5.4.5 Encounters

5.4.6 CMS data reports distributed by Atrio

5.4.7 Risk scores

5.4.8 Referrals and Prior Authorizations

5.4.9 Peer Review, direct observation

5.4.10 Sanction and Monitoring activities

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

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

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

5.4.14 Delivery System Network report

5.4.15 Subcontractor data reports

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

5.4.17 OHA REALD/SOGI Flat File & Repository

5.4.18 Member-collected data from SDoH screenings, Health Risk Assessments, and satisfaction surveys

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

5.5.1 Internally generated performance reports by the Business Intelligence department provides performance status on all OHA Incentive Metrics at both the enterprise and clinic level.

5.5.2 Externally generated reports from clinic EHRs.

5.5.3 Externally generated reports from OHA

5.5.4 Externally generated reports from Atrio

5.5.5 Pareto Intelligence: 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

5.5.6 Maptitude: 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.

5.5.7 Point Click Care (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.

5.5.8 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.

5.5.9 Tableau: 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.

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5.5.10 Plexis/MS SQL: 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).

5.5.11 Medinsight: used to access Medicaid and/or MA data either through direct access to the system or via reports distributed by Atrio.

5.5.12 Find Help dba Healthy Klamath Connect (HKC): a community information exchange (CIE) used to connect members to local community resources with the capability to report on the number of searches, users, referrals, and community services. This allows CCC to evaluate the areas of largest need.

5.5.13 Essette: Case Management Platform with reporting capabilities to track referrals, prior authorizations, and a variety of services, member demographics, and communications.

5.5.14 Programs used for sanction and monitoring activities are described in Credentialing Policy – Appendix 1 PP09002.01

5.5.15 Smartsheets: used for project management and reporting.

Records Management

5.6 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 **Demographic Review:** The process of disaggregating a performance outcome or statistic into various factors to identify if those factors suggest an inequitable outcome for one or more demographic populations. The factors reviewed should include Age, Race/Ethnicity, Language, Disability, Sexual Orientation, Gender Identity.

7 RELATED LEGISLATION AND DOCUMENTS

7.1 Health Insurance Portability and Accountability Act (HIPAA)

7.2 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	Executive Advisory Committee
Committee Review Dates	
Approval Dates	12/28/2023

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