Contents

Section 1: Transformation and Quality Program Information

A. CCO governance and program structure for quality and transformation:

i. Describe your CCO's quality program structure, including your grievance and appeal system and utilization review:

Cascade Health Alliance (CHA) is a coordinated care organization that provides services to Oregon Health Plan members in accordance with laws, rules, regulations and contractual requirements that apply to the Oregon Health Plan. CHA's Quality Management department is composed of a Director and four staff members that complete and oversee the various quality improvement, assurance, and evaluation functions outlined in this document. Within the department, two committees guide the processes and activities of quality management, performance improvement, utilization, access to care and quality of care.

The Quality Management Committee (QMC) is tasked with oversight and development of all activities related to member and provider engagement, quality outcome metrics, community partnerships, quality projects and performance improvement. Local healthcare providers, clinical and administrative staff from network clinics and community partners, CHA Quality Management (QM) department staff and senior leadership comprise the membership of the QMC. Guest speakers from the community often present, as the QMC provides recommendations for fostering community partnerships and projects that will benefit metrics, members, and the community. The activities of the QMC and QM department are reported to CHA's Board of Directors through Chief Medical Officer, Director of Quality Management, and CEO.

Utilization monitoring, grievance system activities, and clinical guidelines and oversight are under the purview of CHA's Utilization Review Committee (URC), in their capacity as clinical advisory panel. The URC is comprised of local specialists and primary care providers who provide expertise regarding second opinions, member and provider appeals and utilization monitoring, including over and underutilization and hospital readmissions.

ii. Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):

CHA QM staff, at the direction of the QMC and the URC, accomplishes quality management and transformation activities. The QMC provides oversight through meetings held eight times per year while the URC convenes monthly. CHA Community Advisory Council (CAC) meetings are attended by the QM director, CCO innovator agent and other CHA staff. CAC feedback informs Transformation and quality activities are informed by through these positions. CHA's CAC is currently comprised of ten members, not including CHA staff or innovator agent. The CAC chairperson is a member of CHA's governing board and is responsible for reporting CAC activities and input to the board.

iii. Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:

Multiple QM staff participate in the community health assessment and improvement plan process via Healthy Klamath, a local partnership composed of staff from a multitude of Klamath County organizations - including CHA, Sky Lakes Medical Center (SLMC), Klamath Health Partnership (KHP), Blue Zones Project, Klamath County Public Health (KCPH), and many others. QM staff and innovator agent report progress to the CAC during this process by helping write, guide, and inform all elements of a county-wide health assessment. The CAC is responsible for reviewing the final assessment, drafting a prioritization matrix, and determining focus areas for the community health improvement plan (CHIP).

iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, local mental health, local government, Tribes, early learning hubs) to advance the TQS:

CHA actively seeks input and participation from local healthcare providers, clinical and administrative staff from network clinics, and other community partners including Klamath County Public Health and Oregon Tech (OIT). Additionally, CHA staff are active participants in several community organizations, including the Klamath Basin Oral Health Coalition, Healthy Klamath, Blue Zones Project, and ad-hoc groups which endeavor to improve the health of the community.

B. Review and approval of TQS

i. Describe your CCO's TQS process, including review, development and adaptation, and schedule:

The draft TQS is developed by the members of the QM Department. The document is then reviewed and revised by CHA's Operational Council (Ops Council), which is comprised of the directors and executive leadership of the organization. In addition to validating that the TQS meets QAPI federal requirements and OHA/CCO contractual requirements, the Ops Council discusses the efficacy of CHA's transformation and quality initiatives and determines which programs should be adopted, adapted or abandoned based on performance. Upon approval by Ops Council, the document is then reviewed by the QMC before final adoption by CHA's governing board. Initial development of the TQS began in December 2017 and various stages of review and approval occurred in first quarter of 2018 prior to submission. QM staff, QMC, and Ops Council will monitor the progress of TQS objectives and projects throughout the year.

C. OPTIONAL – Additional CCO Characteristics

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

CHA serves greater Klamath County, a rural county in Southern Oregon that spans more than 6,000 square miles. The expansive rural nature of CHA's coverage area proves challenging when working on member outreach and engagement. Klamath County is ranked as number 35 of the 36 Oregon counties for overall health outcomes, according to RWJ County Health Rankings for 2018. CHA has continued partnerships with public health, tribal, government and community-based organizations and the local hospital and federally-qualified health center to improve health outcomes in Klamath County. As part of these partnerships, CHA aims to establish a community-informed health assessment and improvement plan that can guide the health outcome improvement work of Klamath County-based organizations.

Section 2: Transformation and Quality Program Details

A. TQS COMPONENT(S) – **Access (Availability of services, Timely access, Second opinions)**			
Primary Component:	Access	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	Access: Availability of services	**Additional Subcomponent(s):**	Timely access, Second opinions

B. NARRATIVE OF THE PROJECT OR PROGRAM

Most CHA members live within 60 miles of us. CHA makes great efforts to ensure members have access to care; all but one primary care provider within our service area is currently contracted. CHA proactively partners with the local family medicine residency program to retain providers via a retention bonus to practice in Klamath County following their graduation. This residency is one of CHA's largest PCP clinics, serving nearly a third of our members. The contract with network providers requires clinics to be ADA accessible, provide access to after-hour services, and offer appropriate CLAS services, including interpretative services. CHA audits and randomly calls clinics to evaluate compliance with these standards. CHA partners with Oregon Mobile Healthcare (OMH) to provide home visits for post-hospital discharge, emergency department (ED) recidivism and preventative services. CHA works with out-of-area providers when a service is not available locally. If additional care is needed from an out-of-area provider, CHA works with providers to establish agreements for members to be seen. These professionals are considered in-network for members. CHA has a policy to ensure all members have access to second opinions from a qualified professional. Non-emergency medical transportation (NEMT) is available to members for in-area and out-of-area appointments.

C. QUALITY ASSESSMENT

Evaluation Analysis:	CHA's annual Delivery Systems Network (DSN) report demonstrates our network offers after-hour services, NEMT, and second opinions. CHA's clinic audits validate that most clinics comply and maintain after-hour services. Some clinics offer same day appointments and extended hours for established members. CHA does not currently track second opinion utilization. Some providers that offer services requiring prior authorizations will not allow a procedure to occur if an authorization has not been processed. CHA strives to quickly process authorization determinations, well under the 14-day timeline; however, providers cannot always request an authorization with enough advanced notice. In July, CHA will begin using a program for auto-authorizations to streamline the authorization process. In 2017, CHA developed agreements with two clinics in Medford to provide dermatology care to members, until a dermatologist is hired to serve Klamath County. CHA has many agreements with additional Medford providers (including gastroenterology, pediatric dentistry, neurology, and other specialties), OHSU, and other providers in Oregon to ensure comprehensive access to all covered services. Second opinions utilization can currently only be tracked through manual review of authorizations. Second opinion authorizations do not contain a separate sub-class or category, and are only denoted through the addition of "second opinion request" in the authorization note. However, it might be possible to add a separate note category for second opinions or an additional second opinion sub-class within the office visit authorization class. Once a workflow or tracking system has been established, utilization of second opinions could be tracked via comparison of approved authorizations versus billed

	second opinion claims (CHA will only know if the claim was for a second opinion based on billing authorization number). CHA does not currently analyze the number of second opinions approved for out-of-area providers, but it is suspected that most specialty second opinions will occur out-of-area due to the limited number of each specialist-type in Klamath County. Of CHA's 10 primary care clinics, 7 offer weekday hours after 5:00 pm, 3 offer weekend hours, and 3 offer drop-in clinic hours. Of CHA's 5 mental health facilities, 4 offer weekday hours after 5:00 pm. Of CHA's 4 SUD facilities, 3 offer weekday hours after 5:00 pm. KBBH provides a 24-hour crisis line, which will be embedded in Sky Lakes' Emergency Department by the end of March 2018 to provide afterhours crisis services.

D. PERFORMANCE IMPROVEMENT

Activity: Implementation and use of MCG CWQI for auto-authorizations				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Status reports	None	3 authorizations (hospital dentistry, nutritional counseling, and oxygen therapy)	07/2018	TBD	TBD

Activity: Member education regarding establishing care at onset of coverage through updating the welcome letter and providing new member outreach				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Monthly reports	Current welcome letter and no workflow for new member outreach	Update welcome letter and create new member outreach workflow	TBD	Contact all new members through the welcome letter and member outreach	TBD

A. TQS COMPONENT(S) – **Social determinants of health, Health information technology (Patient engagement), Health equity (Data)**			
Primary Component:	Social determinants of health	**Secondary Component:**	Health information technology
Additional Components:	Health equity and data		
Subcomponents:	HIT: Patient engagement	**Additional Subcomponent(s):**	Health equity: data

B. NARRATIVE OF THE PROJECT OR PROGRAM

CHA uses reports and information from Electronic Health Records (EHRs) and scheduling systems to inform our efforts in affecting social determinants. NEMT data shows the percentage of members that receive rides versus mileage reimbursements or those who use public transportation. Information is often shared among community partners to help inform work that is being done community-wide. Through a partnership grant program, CHA has utilized data from community partners to demonstrate how organizations can work to transform the system of care. The implementation of the No-show Project stemmed from a hypothesis that a reduction in no-shows will increase or alleviate some access burden, especially among PCPs. Several clinics communicate with their patients using online portals, but members must first be involved and engaged in accessing care.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Analysis from the No-show project and DSN report provides information about access standards and needs for more providers or increased access. Our staff provides outreach as needed to help members get involved with various programs offered by CHA and other community partners. Additionally, through sharing of data and with use of our current HIT, CHA can provide gap lists to clinics for outreach in addition to outreach. Over 500 CHA members completed paper surveys during the fourth quarter of 2017 to demonstrate their satisfaction with local specialists, including anesthesiologists and radiologists. CHA will enhance this surveying protocol, and administer at least once annually to help inform and improve CHA member experience and engagement. Through CHA's Community Project Advisory Committee, CHA has granted funds to 28 community projects that have demonstrated ability to improve social determinants in Klamath County. Since 2017, CHA has funded eight projects related to built environment and neighborhood improvement, including funding for city parks and protected bike lane. Seven grants were given for education projects, including Klamath Promise, a group committed to increasing graduation rates in Klamath County. Ten projects related to social and community health improvement received grants, including funding housing programs with community action and gospel mission. Additional funding was given to youth community centers and other projects related to economic stability and health care improvement.

D. PERFORMANCE IMPROVEMENT

Activity: Ability to collect data around social determinants of health (SDH), including food insecurity	☐ Short-Term Activity or ☒ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
SLMC report "ORPRN social determinants of health screening tool"	No data collection	SLMC implementation of Healthy Planet	12/2018	Collect and utilize data to inform work around SDH	03/2019

A. TQS COMPONENT(S) – **CLAS standards and provider network, Health equity (Cultural competence), Access (Cultural considerations, Quality and appropriateness of care)**

Primary Component:	CLAS standards and provider network	**Secondary Component:**	Health equity and data
Additional Components:	Access: Cultural considerations; Access: Quality and appropriateness of care furnished to all members		
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

CHA's contract with network providers requires clinics to address the cultural and linguistic health of each member. CHA offers use of an interpreter line to CHA staff and clinics. The network has Spanish-speaking providers, including a Spanish-speaking pod at KHP where all staff members speak Spanish. Sky Lakes maintains a video/conference call interpreter service for hospital and Sky Lakes clinics/services. Cultural Competency policy and annual trainings for CHA staff and providers/clinics demonstrate how CHA strives to provide equal opportunity to members for obtaining care that recognizes their experiences, cultural diversity, and other unique needs.

CHA is working with community partners to develop a unified community health assessment and improvement plan (CHA/CHIP). Data from this project and other upcoming projects, including Healthy Planet and Uniform Data Systems (UDS), can provide a better understanding of member demographics. Along with claims, EHR, and member file data, CHA currently utilizes Healthy Klamath and County Health Rankings websites to compare county-level data to CCO data.

C. QUALITY ASSESSMENT

Evaluation Analysis:	CHA's DSN report and equity dashboards produced from state data analyze member demographics and evaluate how CHA provides for their needs. Most members are classified as white, Hispanic/Latino, and "unknown ethnicity." A majority of members speak English while a large population speaks either Spanish or an "undetermined" language. Reports from community health workers, behavioral health, and our language line show how often these services are utilized. We do not have a certified interpreter on staff. QM staff use a variety of data sources to identify vulnerable populations served by the CCO in Klamath County. Data from member enrollment (834 files) can often provide knowledge of race and ethnicity, language, and biological data; however, a large percentage of CHA's membership files lack data. While this does make it difficult to pull accurate reports to determine what the disparities are, QM and Analytics staff have pulled data from the metrics dashboard to bolster current analysis with the member demographic and population data available. The three-

	month claims lag often renders the data obsolete by the time CCOs can access the data. While the data does provide an idea of current trends and a snapshot of our membership over time, CHA is focused on developing and enhancing availability of important population data.

D. PERFORMANCE IMPROVEMENT

Activity: Increase amount of current materials in other language(s) (Spanish), larger print (18+), and audio.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Availability of translated materials	Outdated translated materials	Translate/produce current materials	05/2018	Annual updates to translated/alternative formatted materials	02/2019; 02/2020; etc.

Activity: Improve accuracy of data to better capture the culture of members				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports	State data; no CHA workflow	Create workflow to collect data locally	06/2018	Test ability to collect data	12/2018

Activity: Use equity dashboards to inform equity improvement focus(es)				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Quarterly reports	No equity improvement focus	Choose where to focus improvement efforts	08/2018	Begin equity improvement focus	01/2019

Activity: CHIP-collaboration in unified CHIP to address equity disparities along with CHA process.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Communication between partners	Individual CHIPs	Updated, Unified CHA	07/2018	Unified CHIP	02/2019

A. TQS COMPONENT(S) – **Integration of care, Special health care needs, Severe and persistent mental illness, Health equity (cultural competence)**			
Primary Component:	Integration of care (physical, behavioral and oral health)	**Secondary Component:**	Special health care needs
Additional Components:	Severe and persistent mental illness; Health Equity and Data		
Subcomponents:	Health Equity: Cultural competence	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Integration of care is a core focus for CHA. With this notion, CHA works closely with local organizations and encourages communication amongst them to improve the integration of care. Klamath County's local federally-qualified health center provides physical, behavioral, and oral health in house. During the 2nd quarter, CHA and KBBH are piloting a program where a SPMI cohort will be assigned to KBBH, as a Certified Community Behavioral Health Clinic (CCBHC) for primary care. KBBH also offers Assertive Community Treatment (ACT). CHA offers case management to SHCN and SPMI members. CHA works with Oregon Mobile Health (OMH) and NEMT to improve access to care for members. QM staff will work with CHA's Behavioral Health Coordinator to develop a program around SPMI members and service utilization, as the BH Coordinator has established relationships with many of these members. Members with special health care needs (SHCN) are identified by CHA's Case Management staff in order to determine members who would benefit from one-on-one case management, including risk and need for intensive case management services (ICMS). Most members who are actively case managed are those that fall within CHA's SHCN population, including those with an active diagnosis of any mental health or substance use disorder or those with multiple chronic conditions and either physical or mental disability. The majority of SCHN members are those that have multiple gaps in care, as identified by QM staff. These members are the target focus of CHA's Gap Care program spearheaded through our partnership with Oregon Mobile Healthcare.

Dental services are now coordinated through Cascade Health Alliance, without dental care organizations (DCO) administering dental services to members. Through this process, CHA has centralized reporting capabilities that were previously not available when services were processed under separate DCOs. Through direct contracting, CHA can work dentists and hygienists in providing services at nontraditional locations, such as schools and community centers. To enhance care coordination, CHA has partnered with Sky Lakes Outpatient Care Management to provide care management to non-dual CHA members who receive care from at a Sky Lakes primary care clinic. Through this program, members can interact with nurse case managers and community health workers who help members navigate the health care system, thus more effectively addressing each members' needs in a flexible and easily accessible manner.

C. QUALITY ASSESSMENT

Evaluation Analysis:	CHA's equity (SHCN/SPMI) dashboard analyzes CHA's demographics while CHA's DSN report analyzes how we provide care to those with SHCN and SPMI. QM has drawn attention to health disparities among CHA membership and larger community through the publishing of quarterly equity dashboards that provide snapshots of CHA membership demographics. These dashboards help staff and community partnerships gain a better understanding of the people CHA serves and have the potential to drive and focus improvements around specific distinct and vulnerable populations. CHA is in the process of developing a method to improve the accuracy of dashboards, as data comes from multiple sources. Overall, QM plans to introduce the equity lens steadily, insisting on inclusion of equitable interventions and interactions in all programs and projects across departments.

	QM is working to develop reports that will allow staff to pull real-time data to help identify members with SPMI and relevant effecting factors more accurately. Understanding the demographics of this population will be a key step in developing an effective program to reduce the number of members with SPMI using the emergency department for non-emergent needs. As of Q4 2017, members with SPMI had an ED utilization rate of 98.7 visits per one thousand member months compared to an overall ED rate of 43.3 visits per one thousand member months in the same quarter of the measurement year. While these perfunctory analyses show a great disparity in care for members with SPMI in Klamath County, additional analysis of no-show, primary care and mental health utilization and access to care is needed to begin fully understanding this population. CHA has identified a population of geographically isolated members that are at greater risk for decreased PCP access and utilization and therefore, increased risks of hospital admission or emergency department utilization. In 2017, CHA worked with Sky Lakes and other local providers to expand this program. CHA has expanded its relationship with Sky Lakes Outpatient Care Management to offer care management services to a wider population. Through this partnership, CHA members can more readily access the services of a community health worker, who may provide transportation, in-home care, and health education to members that are facing multiple barriers in accessing care. While CHA is required to cover Applied Behavioral Health (ABA) services, no services are currently available locally. CHA is working with OIT to establish an ABA clinic that would be able to provide services to OHP members in Klamath County. OIT currently has two board-certified behavioral analysts (BCBA) providers who will staff the clinic, meanwhile teaching and supervising student assistant behavior analysts and behavior technicians.

D. PERFORMANCE IMPROVEMENT

Activity: Pilot assignment of SPMI to KBBH for PCP				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Member assignment and reports of service utilization/engagement	No members in this program	Assign a pilot cohort to KBBH	2018Q2	Evaluate program	2018Q4

Activity: Warm handoffs ED providers to KBBH Crisis Team in the Emergency Department (ED).				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Reports/data from KBBH	Cold handoffs	Warm handoffs	04/2018	Referrals for MH/SUD assessment through Crisis Team	6/2018

A. TQS COMPONENT(S) – **Utilization review, Access (Quality and appropriateness of care)**			
Primary Component:	Utilization review	**Secondary Component:**	Access
Additional Components:			
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

CHA has a Utilization Review (UR) Policy to ensure proper UR occurs. The Chief Medical Officer (CMO) oversees and provides UR. Case Management (CM) monitors their productivity and authorization timelines. Quality Management (QM) monitors authorizations, appeals, and grievances in conjunction with inter-rater reliability audits performed through the Compliance department. Interventions will improve timeliness and consistency of UR activities and seek to manage utilization by preventing unnecessary care.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Case Management monitors productivity and authorization processing timeline and desires to reduce times and increase productivity. Analysis suggests that some authorizations are rarely denied and that UR activities are providing little value. Feedback from providers and CHA reports highlight inconsistency in medical decision making as an opportunity for improvement. Medical, pharmacy, and behavioral health (BH) authorizations are not currently evaluated through inter-rater reliability (IRR). CHA and its provider partners prioritize monitoring ED utilization and providing case management to frequent users. Overutilization of the emergency department (ED) continues to be a challenge. A formal root-cause analysis has not been performed. Providers currently do not receive utilization reports from CHA and many would be open to learning from them. Medical management is primarily reactive. CHA has useful reporting and analytic tools that are underutilized.

D. PERFORMANCE IMPROVEMENT

Activity: Compliance will implement monitoring interrater reliability (IRR) of utilization review analysts, case managers, and medical directors				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Essette reports, review, and work instructions	IRR reports only for dental services	Implement IRR for medical service, BH and pharmacy reviews	06/2018	IRR for all service types timely and consistently performed	12/2018
Activity: Authorization processing time improvement—implement auto authorizations based on OHA rules and MCG guidelines				☒ Short-Term Activity or ☐ Long-Term Activity	

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Median time to completion	8 days	6 days	08/2018	5 days	12/2018
Activity: Pharmacy prior authorizations (PA) processed through Essette – the same system as Case Management				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Workflow development and implementation	PAs completed through DocRecords and MedImpact	Workflow development	07/2018	Utilization of Essette for pharmacy PAs	09/2018
Activity: CHA will address ED utilization by convening community partners including Sky Lakes Medical Center, Sky Lakes Outpatient Care Management, KBBH and primary care providers. Root causes of unnecessary ED use will be identified and addressed when possible.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Monitor the overall ED utilization quality metric	43.6/1000 member months	40.0/1000 member months	12/2018	35.0/1000 member months	12/2019
Activity: CHA will conduct a formal ED utilization root cause analysis in partnership with Sky Lakes Medical Center, Klamath Health Partnership and other necessary community partners.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Root-cause analysis	No formal root-cause analysis	Root-cause analysis	6/2018	Root-cause analysis	6/2018

A. TQS COMPONENT(S) – **Grievances and appeals, Access (Quality and appropriateness of care)**			
Primary Component:	Grievances and appeals	**Secondary Component:**	Access
Additional Components:			
Subcomponents:	Access: Quality and appropriateness of care furnished to all members	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

CHA's Grievance System is comprised of Grievances, Appeals and Hearings. This system is inclusive of complaints, NOAs, appeals and hearings. CHA has written policies and procedures in the form of Operating Instructions (OI) and attachments for the grievance, appeal and contested case hearings processes. These processes meet requirements of OAR 410-141-3225 through 410-141-3255 and 42 CFR 438.400 through 438.414.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Appeal and Grievance quarterly reports monitor progress throughout the year. All Grievances, Appeals and Hearings are tracked in a spreadsheet on a quarterly basis which is incorporated into the quarterly Grievance System Analysis report. This report is comprised of completeness, accuracy and timeliness of action, documentation, compliance with written OIs and Attachments and disposition of cases. The quarterly Grievance System Analysis report is presented to CHA's UR Committee and forwarded to OHA.

D. PERFORMANCE IMPROVEMENT

Activity: Denied authorizations (NOAs) regularly need to be present in Essette UM module to provide consistent distribution to member/provider and dependable availability for Appeal and Reconsideration processing.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Inter-Rater Reliability/progress report	No workflow	Workflow developed	06/2018	Workflow Implementation	07/2018

Activity: A member-provider reassignment process will be developed to integrate and systemize the process of reassigning members, so it is easily tracked and all parties are aware of change in a timely and consistent manner.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
PCP history (Plexis & EZCAP)	No workflow	Workflow developed	05/2018	Workflow Implementation	06/2018

Activity: Denied Authorization (NOA) second review process relating Medical Director may contact service/issue provider if Reconsideration of denial is more appropriate than the Appeal & Hearing process. There is potential for performance improvement with: progressive member services, enhanced provider relations and decreased number and/or duration of Appeals. Expectation is that Reconsiderations would increase, but it would be the result of an improved and more appropriate process.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Appeal Withdrawals and Reconsideration Requests Reporting	No workflow	Workflow developed	05/2018	Workflow Implementation	07/2018
Activity: Application of Tobacco Cessation timelines to denied authorizations (NOAs). Stipulation allowing tobacco users who cease use within 60 days of NOA to access denied service without provider having to request authorization of service again. A reduction of processes and time for providers and CHA staff is anticipated. Applicable timelines developed to encompass Appeal request regarding denial for Ancillary Guideline A4.				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Inter-Rater Reliability/progress report	No workflow	Workflow developed	06/2018	Workflow Implementation	07/2018

A. TQS COMPONENT(S) – **Fraud, waste and abuse, Access (Timely access)**

Primary Component:	Fraud, waste and abuse	**Secondary Component:**	Access
Additional Components:			
Subcomponents:	Access: Timely access	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

As an element of CHA's compliance program, we conduct annual provider site reviews to monitor our fraud, waste and abuse program. Data collected from these site visits include encounter data validation, chart reviews and administrative review (policies and procedures, ADA compliance, current documentation, etc.). The data is recorded, tracked and trended. Audit results are presented to the Compliance Committee annually. 2017 reviews did not result in any referrals to the OHA/DHS Provider Audit Unit/Medicaid Fraud Control Unit (PAU/MFCU); however, one clinic was placed on a corrective action plan (CAP) to address data insufficiencies and inadequate charting.
As part of CHA's program integrity work, CHA sends service validation letters (SVLs) to randomly selected members each month to verify services from contracted providers. The data is categorized by number of letters sent, response rates, number of returned letters due to invalid address, and the number of discrepancies in billed services. Data is tracked monthly.

CHA's Utilization Review Committee performs reviews of service claims to identify outliers for both over-utilization and under-utilization of services. Currently, imaging, physical and occupational therapy, and alternative therapy (chiropractic and acupuncture) services are reviewed through this process.

C. QUALITY ASSESSMENT

Evaluation Analysis:	All network providers are included in the annual site review/audit plan. The 2017 audits reviewed a randomly selected sample of 10% of 2016 claims for each provider. One clinic was determined to be non-compliant, which initiated a 100% review of all 2016 claims for that clinic. A CAP was developed for the clinic; however, it was presented months later due to the compliance committee and board-level approval process. The 2018 audits will consist of a 1% (5-chart minimum) review, unless a clinic is on an active CAP, which will result in a 100% chart review. In 2017, 580 SVLs were sent to CHA members. 22 were returned with invalid addresses. Member response rate was 231/580, or 39.8%. Eight of the responses were referred for investigation; and of those, all were services were validated. The compliance department will explore methods to increase response rate. Additionally, tracking frequency will increase to quarterly. Activities in 2017 did not include exhaustive assessment of fraud, waste and abuse through analysis of duplicative services, appropriate place of services and appropriate level of care. The compliance plan and FWA policy were reviewed and revised to enhance monitoring activities and evaluation for greater effectiveness of CHA's compliance program.

D. PERFORMANCE IMPROVEMENT

Activity: The compliance committee meets quarterly. Special meetings will be convened when audits reveal significant non-compliance.

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Final report and CAP dates	4 months to final report and CAP	45 days to final report and CAP	01/2018	45 days to final report and CAP	12/2018

Activity: Develop process and tool for inpatient and ambulatory care services site review/audit.

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Development of review/audit tool and process	No audit tool or process.	Audit process	06/2018	Audit tool	08/2018

Activity: SVL analysis and utilization

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Formal written analysis and utilization of analysis	Annual	Quarterly	08/2018	Integration of analysis with compliance program evaluation plan	01/2019

Activity: Evaluation of compliance program

☒ Short-Term Activity or
☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Development, approval and implementation of evaluation plan	No plan in place.	Plan developed and approved	10/2018	Plan implemented	01/2019

A. TQS COMPONENT(S) – **Health information technology (Analytics)**			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Analytics	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Currently, CHA employs two main analytics tools, PHTech Inteligenz and Metrics Manager, and Milliman PRM Analytics. CHA also has access to an additional analytics and reporting solutions through Reliance eHealth Collaborative, formerly Jefferson Health Information Exchange (JHIE). PHTech is primarily utilized by Quality Management staff in tracking quality incentive metrics and has the capacity to report on potential fraud, waste and abuse. PRM Analytics is another claims-based tool that CHA has extensively developed to help track chronic conditions, ED utilization, and adverse scenario/potentially avoidable risk rankings. PRM is primarily used by case management staff to identify potential CHA members for care coordination, either internal or via partnership with Sky Lakes Outpatient Care Management.

C. QUALITY ASSESSMENT

Evaluation Analysis:	IT is working on analysis of current tools and possibilities of different solutions that may include AI computing along with the predicative analytics and BI tools of the other solutions. Currently, CHA can analyze claims-based data; however, data has to be run and then analyzed separately. CHA does not have an analytics tool for utilization or monitoring. Through PHTech, CHA is able to provide gap lists to network providers to help focus interventions on members that have gaps in preventative care. CHA continues monthly calls with PHTech in order to validate all data is correctly processed. These touch points also provide an avenue for information and updates regarding new program abilities and features. Throughout 2016 and 2017, CHA has continued to work with provider and clinics to develop reports for EHR-based clinical quality metrics. CHA was successful in working with SLMC and OHSU in the development of a smoking status report that will allow all SLMC PCP clinics to report smoking statuses for CHA members, consistent with the smoking prevalence quality metric. CHA continues to provide support to clinics regarding workflow development and documentation challenges. For example, CHA is currently working with KHP to develop enhanced documentation of prenatal and maternity care.

D. PERFORMANCE IMPROVEMENT

Activity: PRM Analytics by Milliman training for staff in 2018	☒ Short-Term Activity or ☐ Long-Term Activity

How activity will be monitored for improvement	Baseline or current state	Target or future state	Time (MM/YYYY)	Benchmark or future state	Time (MM/YYYY)
Completion of training	Less than >10 staff trained	QM and CM staff trained (>20)	05/2018	QM, CM, Pharmacy, and Engagement staff trained (>30)	07/2018
Activity: Workflow development for utilization of analytics tools				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Reports produced by proper tool	Inconsistent use of analytics tools	Workflow developed to guide the utilization of each tool	07/2018	Each department using workflow as a guide to analytics tool use	09/2018

A. TQS COMPONENT(S) – **Health information technology (Health information exchange)**			
Primary Component:	Health information technology	**Secondary Component:**	Choose an item.
Additional Components:			
Subcomponents:	HIT: Health information exchange	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

Reliance has reporting capabilities and consolidated patient charts. Reliance is redesigning their portal to be released during second quarter of 2018. The new portal will include an enhanced community chart. HIE clinical data is being fed into Essette via HL7.
Case Management staff are being trained in the utilization of PreManage. Cohorts can be established which will allow for identification of ED utilization, possibility of alerts and campaigns to be established for increased ease in tracking ED visits. CHA plans to use this cohort function to identify trends of use among SHCN and SPMI populations, among others.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Currently, 10% of HIE/HL7 data does not match a member ID now. Member ID is the only way HL7 data is matched to a member/patient. Clinics do not have to participate in both HIE data sharing and portal data sharing, so some clinics may provide more information than others. A workflow does not exist for how PreManage can be utilized most efficiently, including which alerts should be setup and what constitutes use-case for PreManage versus Reliance versus Essette HL7 messages. PreManage could be used to alert on ED visits for

	SPMI cohort (ED Use in MI metrics). All PCP clinics in Klamath County are currently engaged with Reliance in sending either HL7 messages or participating in the Reliance portal.

D. PERFORMANCE IMPROVEMENT

Activity: Development of workflow for use of HIE/PreManage for all relevant departments				☒ Short-Term Activity or ☐ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Workflow developed	No workflow	Workflow for CM and QM	7/2018	Workflow for Pharmacy and Engagement	9/2018

Activity: QRDA/EHR-based reports				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Ability report in QRDA format	# of reports currently required from other sources (SLMC, KHP)	TBD # of reports Reliance can pull currently	10/2018	4 EHR-based reports Reliance could pull	04/2019

A. TQS COMPONENT(S) – **Value-based payment models, Patient-centered primary care home**

Primary Component:	Value-based payment models	**Secondary Component:**	Patient-centered primary care home
Additional Components:			
Subcomponents:	Choose an item.	**Additional Subcomponent(s):**	

B. NARRATIVE OF THE PROJECT OR PROGRAM

A component of CHA's value-based payment (VbP) model includes capitation and risk sharing agreements in which CHA shares risk on overall CCO performance with participating hospital, specialists and primary care providers. An additional component of the VbP includes incentive payments for participating hospital, primary care provider and some specialists who meet performance improvement targets for patient and population health. CHA uses quality health outcomes metrics to show how well clinics are improving care, making quality care accessible, eliminating health disparities and curbing the cost of care.
CHA's VbP model also includes a tiered-bonus payment starting at the tier-3 level and increasing to the 5 Star level of PCPCH certification.

C. QUALITY ASSESSMENT

Evaluation Analysis:	Evidence has shown providers are increasingly moving towards value-based reimbursement. This model encourages clinicians and institutions to change the way they deliver care in order to reduce cost growth, improve health care quality outcomes and population health. CHA implemented an incentive payment program that is modeled after the OHA's CCO Incentive Metric program. This model has proven effective, with each clinic improving on almost every measure for each of the last three years. CHA will continue to base incentive disbursement on each clinic's share of metrics improvement.

	As of January 2018: three clinics are tier 4 and six clinics are tier 3. This accounts for 9 of 10 PCP clinics, as one PCP clinic has not yet applied for PCPCH certification. One tier-4 clinic applied for 5 Star certification and is awaiting site review, expected to be completed in 2018.

D. PERFORMANCE IMPROVEMENT

Activity: Measure each clinic's performance against the improvement target the OHA sets for CHA each year. Clinics that perform better than the target earn incentive payments.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Each clinic will be challenged to meet or exceed CHA's improvement targets.	2017 performance – TBD	All clinics meet or exceed CHA's improvement targets.	12/2018	All clinics meet or exceed CHA's improvement targets.	12/2019
Activity: Tiered bonus payment for PCPCH recognition.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Number of clinics paid through tiered-bonus payment	4x clinics paid per tier; 5x clinics not paid through PCPCH tier	9x clinics paid per tier-structured payment	6/2018	10x clinics paid per tier-structured payment	6/2019
Activity: Support clinics in their attempts to increase tier levels.				☐ Short-Term Activity or ☒ Long-Term Activity	
How activity will be monitored for improvement	**Baseline or current state**	**Target or future state**	**Time (MM/YYYY)**	**Benchmark or future state**	**Time (MM/YYYY)**
Status of PCPCH certification	3x clinics at Tier 4 6x clinics at Tier 3 1x clinic non-PCPCH	1x 5 Star 2x Tier 4 6x Tier 3 1x certified at any level	12/2018	1x 5 Star 4x Tier 4 5x Tier 3	6/2019

Section 3: Required Transformation and Quality Program Attachments

A. Attach your CCO's quality improvement committee meeting minutes from three meetings
B. Attach your CCO's consumer rights policy
C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.