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 management review:

Cascade Health Alliance (CHA) provides services to Oregon Health Plan members in accordance with all relevant laws, rules, regulations, and per its contract with the Oregon Health Authority. CHA's Quality Management department is composed of a Director of Quality Management, Quality Management Analyst, and a Quality Management Specialist (who also serves as CHA's Credentialing Specialist). The Quality Management Department is responsible for completing the various quality improvement, assurance, and evaluation functions outlined in this document. The Chief Medical Officer bears ultimate responsibility for the Quality Management Department. Additionally, the Quality Management Committee (a Board Committee) guides the processes and activities of quality management, performance improvement, and credentialing.

The Quality Management Committee (QMC) is tasked with oversight and development of all activities related to OHA's Incentive Metrics, credentialing, and quality and performance improvement projects. 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. The activities of the QMC and QM department are reported to CHA's Board of Directors through the Chief Medical Officer, Director of Quality Management, and CEO.

The Utilization Review Committee (Board Committee), while not under the Quality Management umbrella, guides CHA's processes and activities related to utilization review, access to care, and quality of care through monthly meetings. The Utilization Review Committee (URC) serves as the organization's Clinical Advisory Panel in its duties to monitor utilization (over and under-utilization), hospital readmissions, as well as review and oversight of clinical guidelines. The URC is comprised of local specialists, primary care providers, and a representative from the Community Mental Health Program who provide expertise regarding second opinions, member and provider appeals.

The Compliance Committee (another Board Committee) has ultimate oversight over member grievances and appeals as well as the company's fraud, waste, and abuse program. This Committee is attended by the Chief Compliance Officer and the Compliance Coordinator, as well as local providers and clinic administrators.

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, plans and executes quality management and transformation activities. The QMC provides oversight through meetings held throughout the year. CHA's Community Advisory Council (CAC) is currently composed of 10 members (not including CHA staff or the CCO Innovator Agent) and is chaired by a member of CHA's governing Board and is therefore responsible for reporting CAC activities and recommendations to the Board of Directors. Meetings are attended by the Director of Quality Management, the CCO Innovator Agent, various community partners, CHA members, and other CHA staff as needed. CAC feedback informs transformation and quality initiatives, including this Transformation and Quality Strategy.

QM staff identify improvement opportunities through its review and analysis of health outcomes data, research on best practices in healthcare, community partnerships and stakeholder meetings, and technical

assistance opportunities offered by the Oregon Health Authority. Identified opportunities are brought before the CAC, the QMC, and CHA's Operations Council (composed of all Directors and Executive Leadership) for consideration and feedback.

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

The Quality Management department participates in the development of the Community Health Assessment and Improvement Plan through Healthy Klamath, a local partnership composed of staff from a multitude of Klamath County organizations, which include CHA, Sky Lakes Medical Center (SLMC), Klamath Health Partnership (KHP), Blue Zones Project, Klamath County Public Health (KCPH), and many others. QM staff and the CCO Innovator Agent report progress to the CAC throughout the process. The CAC's recommendations help guide and inform the development of all elements of the county-wide health assessment. The CAC is responsible for reviewing the final assessment, drafting a prioritization matrix, and providing recommendations which inform the development of the Community Health Improvement Plan. Additionally, the CAC identifies priority areas in addition to those identified by Health Klamath on which to focus its efforts during the review period.

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

CHA actively seeks recommendations and participation from local healthcare providers, clinical and administrative staff from network clinics, Klamath County Public Health, local behavioral healthcare providers (4), Oregon Institute of Technology (which provides a Population Health tract), and other community partners. Additionally, CHA staff are active participants in several community organizations, including the Klamath Basin Oral Health Coalition, Healthy Klamath, Blue Zones Project, health equity activities of Klamath County Public Health, Klamath County Local Public Safety Coordinating Council (LPSCC; serves as the local Opioid Prevention Task Force), You Matter Klamath (Suicide Prevention), Early Learning Hub, 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 development process, including review, development and adaptation, and schedule:

The draft TQS is developed by the QM Department. The department's recommendations are brought before the CAC for review and discussion as well as the QMC. After the recommendations of the CAC and QMC have been incorporated into the document, it is reviewed again by the QM Department to ensure compliance with QAPI federal guidelines, and Oregon Health Authority and CCO contractual requirements. The document is then taken before CHA's Operations Council (Ops Council). The Ops Council reviews the efficacy of CHA's transformation and quality initiatives to determine which programs should be adapted or abandoned based on performance, and which new initiatives should become CHA's focus going forward. In addition to regular review of progress toward current TQS initiatives, initial consideration of revisions or additions began in December 2018. Recommendations were brought to the CAC (January 2019 meeting) and QMC (February 2019 meeting) for consideration and review at their respective meetings. QM staff, the QMC, and the Operations Council will monitor the progress of TQS objectives and projects throughout the year and keep the relevant stakeholders updated as needed.

C. OPTIONAL

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 in engaging members, outreach, and education efforts. Klamath County is ranked as number 35 of the 36 Oregon counties for overall health outcomes, according to RWJ County Health Rankings for 2018.

A recent Performance Improvement Project aimed at deciphering the barriers to members keeping scheduled appointments ("no show" rate) revealed that those members who fail to keep their scheduled appointments also carry on average, 6 ACEs (Adverse Childhood Experiences) indicating a high level of trauma amongst CHA members. Therefore, CHA's TQS will focus on those Social Determinants of Health where member education and engagement will have the greatest impact on health outcomes.

CHA has established and maintained strong partnerships with its many community stakeholders to improve health outcomes in Klamath County. These strong partnerships and community-wide efforts were the cornerstone to Klamath County being chosen as one of six Robert Woods Johnson Foundation's Culture of Health Prize Winners in 2018. CHA works closely with its community partners to ensure that the health messages being received by all members of the community are consistent and reflective of best practices in healthcare. Community partnership is reflected in CHA's 2019 Transformation and Quality Strategy.

Section 2: Transformation and Quality Program Details

(Complete Section 2 by repeating parts A through F until all TQS components and subcomponents have been addressed)

A. Project or program short title: **Health Equity Project 1: Improve/Increase Data Collection and Analysis Capacity to Inform Member Needs**

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

B. Primary component addressed: Health equity

i. Secondary component addressed: Health information technology
ii. Additional component(s) addressed: Patient Engagement
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Health Equity: Data

i. Additional subcomponent(s) addressed: Timely Access to Services

D. Background and rationale/justification:

CHA has previously used multiple software programs to gather population health data, none of which were fully integrated resulting in fragmented data, or data that was not useful in accurately identifying opportunities for improvement or the needs of our members. Many CHA members do not have easy access to digital technology to support them in their efforts to manage their own health and healthcare services.

E. Project or program brief narrative description:

CHA will integrate its data programs to provide accurate and validated population health data on its members which will be used to identify opportunities for improvement and inform member outreach, engagement, and education strategies. Information will be used to inform CHA's efforts to identify and remediate those Social Determinants of

Health impacting the health outcomes of our members. 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. CHA is developing its data capacity to include Tableau and Pareto to provide deeper level analysis of member demographic data to better inform our efforts to reach members and better meet their needs. CHA is also leveraging its partnerships with Klamath Health Partnership, Sky Lakes Outpatient Case Management, and Oregon Mobile Health to gather Social Determinants of Health data on its members. The data will be used to plan and execute strategies to meet member needs.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Collect and analyze population health data around Social Determinants of Health; use data to inform outreach, education efforts, and service needs. CHA is partnering with Klamath Health Partnership, Outpatient Case Management, and Oregon Mobile Health to gather SDOH data during direct engagement with members.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Integrate SDOH data into current equity dashboard to guide equity improvements to improve member health outcomes.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Fragmented data collection	Integrated data systems with accurate and validated member data	09/2019	Use population health data on Social Determinants of Health to better inform member outreach, engagement, and education programs and strategic plans	12/2019; 12/2020, etc. Integration and use of this data are an ongoing effort to inform equity work on behalf of our members

Activity 2 description: Improve accuracy of data collection to better capture all member needs.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monthly reports demonstrating updated member information, including number of outreach calls and visits conducted.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Currently relying on data provided by OHA. Data is incomplete and does not include SDOH	Work flows created to allow for the collection and verification of member data provided by the OHA	06/2019	Ongoing evaluation of the accuracy of the data provided by the OHA through member outreach; demonstrated	12/2019; 12/2020, etc. Integration and use of this data are ongoing efforts to inform equity work

	by Member Services through member outreach		decrease in the number of provider complaints that member level demographic data is inaccurate	on behalf of our members

Activity 3 description (continue repeating until all activities included): Member education regarding establishing care at onset of coverage.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Collect and analyze data (assigned, no claim for appointment) on a monthly basis to inform member outreach and education efforts regarding establishment of care with assigned mental and/or dental provider at onset of coverage to avoid lengthy appointment wait times.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Mental/Dental Member Handbook is outdated	Updated Mental/Dental Member Handbook	09/2019	Consistently executed member outreach efforts through member services for those members with mental and dental only coverage; continue member outreach efforts for PCP care establishment	12/2019

Activity 4 description: Implementation and execution of Access Mobile as part of a comprehensive digital member engagement strategy.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Implementation of digital member engagement strategy including distribution of mobile devices to members.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Strategy in beginning stages with consultations with vendor occurring; and baseline data being gathered	Based on member data, strategy and timeline for execution documented; initial implementation stages in progress	12/2019	Execution sustained, mobile devices consistently distributed to qualified members; data gathered and analyzed and used for identification of	12/2020 and ongoing

			improvement opportunities	

A. Project or program short title: CLAS Standards and Provider Network Project 2: Translation and Alternative Formats of Member Materials

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

B. Primary component addressed: CLAS standards and provider network

iv. Secondary component addressed: Health equity
v. Additional component(s) addressed: Cultural Competence
vi. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Cultural considerations

ii. Additional subcomponent(s) addressed: Social Determinants of Health

D. Background and rationale/justification:

Materials distributed to members must be translated and readily available upon member request in order to better serve the needs of our members. Alternative formats must also be readily available to members. Currently, not all member materials are immediately available in Spanish or alternative formats. The member handbook is available in both large print and Spanish. CHA continues efforts to recruit a local, certified translator (Spanish) who can work with these materials and is easily accessible for annual updates to existing documents and new materials.

E. Project or program brief narrative description:

Contracts with network providers requires clinics to address the cultural and linguistic needs 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 Klamath Health Partnership (FQHC) in which all staff members speak Spanish. Sky Lakes maintains a video/conference call interpreter service for the hospital and its clinics/patient services. Clinics are required to provide CHA with their Cultural Competency policy at the time of initial credentialing and every three years upon re-credentialing. CHA provides annual trainings in cultural competency for CHA staff and providers/clinics demonstrating our commitment to provide equal opportunity to all members in obtaining care that recognizes their experiences, cultural diversity, and other unique needs.

CHA continues to work with community partners in developing a unified community health assessment and improvement plan (CHA/CHIP). Data obtained from our community partners through this process, as well as data obtained from integrating our many data collection programs, provides CHA with a better understanding of our 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.

Prioritizing materials to be translated based on our member and community demographic data is a key focus for improvement.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Increase the amount and type of materials immediately available to members in different languages and alternative formats.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monthly review of materials translated; establish Gantt chart of materials needing translation, prioritize, and schedule for completion.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Minimal materials translated to Spanish	Translate all member materials, including outreach and community event materials	12/2019	Annual updates to translated materials; continued translation of all posted outreach and community event materials	12/2020; 12/2021, etc.

Activity 2 description: Increase the amount and type of materials immediately available to members in alternative formats.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monthly review of materials created in alternative formats; establish Gantt chart of materials needing to be converted into alternative formats, prioritize, and schedule for completion.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Limited materials available in alternative formats	Member materials available in alternative formats (large print, audio)	03/2020	Annual updates to alternative format materials	3/2020; 3/2021, etc.

Activity 3 description (continue repeating until all activities included): Create and execute a referral process for members to culturally and linguistically appropriate community resources and services.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Review of CHA website monthly to ensure timely upload of current information; maintenance of community partnerships; and regular review of available community resources, especially those offered in outlying areas.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Minimal resource list available for members whose primary language is not English	Creation of a complete list of all available community resources in multiple languages	12/2019	Ongoing monitoring of community resources; continuous cultivation of those community partnerships; and continuous revision of resources available to non-English speaking	12/2020

			members; regular posting and updating of these community resources on CHA website	

Activity 4 description: Provide training on multiple aspects of Social Determinants of Health and Health Equity (i.e. ACEs, implicit bias, cultural awareness, health literacy, etc.) for CHA staff team to further our understanding of the challenges faced by our members.

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: Documented training of staff team

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Implicit bias training held annually; CHA staff have not had recent training in cultural competence, ACEs, or member demographics	Broad SDOH-HE training for current staff team; establish training plan and timeline	07/2019	Ongoing, regularly scheduled SDOH-HE training for staff; and extended to providers upon request	03/2020 and ongoing

A. Project or program short title: Utilization Review Project 3: Emergency Department Utilization

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

B. Primary component addressed: Utilization review

vii. Secondary component addressed: Integration of care (physical, behavioral and oral health)
viii. Additional component(s) addressed: Severe and Persistent Mental Illness
ix. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☒ Oral health integration

C. Primary subcomponent addressed: HIT: Health information exchange

iii. Additional subcomponent(s) addressed: HIT: Analytics

D. Background and rationale/justification:

Vulnerable populations (those with Special Health Care Needs, multiple chronic conditions, SPMI, and/or a physical disability) are disproportionate utilizers of the ED. CHA conducted a root cause analysis of ED use within the Klamath County healthcare system to determine areas for improvement to decrease the use of the ED for non-emergent care. Emergency department utilization may be indicative of many issues within the health care system: lack of timely access to a PCP, need for member education about the importance of preventative services, and a greater need for member outreach and case management services. Among CHA's population, members with a disability use the ED over 1.5 times the rate compared with CHA's overall population. While there have been attempts at member education regarding appropriate ED use from both the plan as well as PCP clinics, communication/outreach attempts and interventions aimed at members with frequent ED visits have historically been disjointed and siloed. Previous attempts to address the issue have been specific to individual clinics and their assigned population with a focus on primary care. A collaborative

effort with inclusion of mental health, emergency department providers, and primary care is now underway being led by CHA's Quality Management team. Additionally, only one local provider utilizes Collective Medical (previously EDIE/PreManage) to manage ED utilization. Expanding use of this platform to all providers will assist in more effective and efficient management of frequent and high-profile ED utilizers.

E. Project or program brief narrative description:

In collaboration with multiple community partners, including behavioral health, primary care, and outpatient care management, two case management groups will be convened to assist those with complex and/or chronic conditions (including those members with mental illness) to manage their health care needs without use of the ED for preventative services. The first group is composed of case and/or care managers from multiple agencies who will meet regularly to discuss best practices, successes, and lessons learned in case management of challenging populations. The second group is composed of those individuals from multiple agencies with decision making responsibility to create a "system of care" for frequent ED users. This group is designed to investigate and remove barriers to the acquisition of non-emergent care, including barriers related to social determinants of health (for example, transportation to appointments, childcare, choice between work or medical appointment, etc.) as well as healthcare system barriers to care (for example, same day appointments, after hours availability of providers for consultations, etc.) in order to achieve a significant reduction in overall ED use. CHA, in conjunction with its community partners, will explore new ways to utilize data to make a meaningful impact on the care of our members and the community as a whole, which can then be utilized to further improve care and service delivery to members of disparate populations, including those with a mental illness, chronic conditions, and/or a disability.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Case/Care Management Best Practices Learning Collaborative

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Learning Collaborative meetings are held monthly. Directors and/or Case Managers report back on progress.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No collaborative or learning opportunity established in the healthcare community	Case/Care Management Learning Collaborative established and meeting regularly	05/2019	Learning Collaborative is successfully sustained and considered a valued part of the Klamath County healthcare system	12/2020

Activity 2 description: Creation and execution of a Complex/Chronic Disease "System of Care" for the Klamath County community

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Network meets monthly or more frequently if necessary to triage and/or staff challenging cases; sustained meetings as evidence of success as well as decrease in ED utilization by members discussed.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No community forum established to collaboratively manage community members' chronic or complex diseases/illnesses	Establishment and implementation of a community-wide "system of care" to manage those individuals with chronic and/or complex diseases/illnesses to prevent unnecessary ED utilization	05/2019	"System of Care" successfully executed and sustained and considered a valued part of the Klamath County healthcare system	12/2020

Activity 3 description (continue repeating until all activities included): Collective Medical (previously EDIE/PreManage) access implemented among providers, and sustained use by all local clinics/providers, including behavioral health and oral health providers.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Demonstrated use of the platform by providers and those staff participating in the Care Network.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
One local provider actively using Collective Medical to manage ED utilization	60% of all local clinics/providers utilizing Collective Medical to manage ED utilization	12/2019	90% of all local providers/clinics utilizing Collective Medical to manage ED utilization	12/2020

A. Project or program short title: Value-Based Payment Models Project 4: Payment Methodology

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

B. Primary component addressed: Value-based payment models

x. Secondary component addressed: Patient-centered primary care home

xi. Additional component(s) addressed: Social Determinants of Health

xii. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Health Equity: Data

iv. Additional subcomponent(s) addressed: Add text here

D. Background and rationale/justification:

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 the local hospital, specialists and primary care providers. An additional component of the model includes incentive payments for the hospital, primary care providers and some specialists who meet performance improvement targets for patient and population health. CHA uses health outcomes and population health metrics to demonstrate how well clinics are performing to improve care and accessibility and eliminate health

disparities while curbing the cost of care. CHA's VbP model also includes a tiered-bonus payment for PCPCH certification, starting at the tier-3 level with increasing payments to the 5 Star level.

In 2018, CHA updated its payment methodology to enhance the community benefit for clinics whose performance helped the Klamath County community meet or exceed the targets for each incentive measure. Clinics continue to receive weighted credit for numerator success achieved on each measure. CHA meets monthly with each clinic to review performance toward the measure targets and facilitate the sharing of best practices and successes in order to assist clinics in meeting each of the measures.

E. Project or program brief narrative description:

Gather performance data by clinic by measure; display as dashboard, run charts displaying performance this year vs. last year vs. target. Monitor individual clinic performance by analyzing data, identifying opportunities for improvement and/or performance improvement projects, and providing technical assistance where needed.

F. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Measure each clinic's and/or provider's performance against the improvement target set by OHA for each Incentive Measure. Clinics that meet or exceed the target earn incentive payments.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Challenge each clinic and/or provider to meet or exceed each Incentive Metric; performance data reviewed and analyzed weekly.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2019 Performance Target for each incentive metric	All clinics meet or exceed CHA's improvement targets for each metric	12/2019	All clinics meet or exceed CHA's improvement targets for each incentive metric upon final determination	03/2020

Activity 2 description: Integrate member demographic and SDOH data into clinic performance data for in-depth analysis and assist in identifying opportunities for improvement with greatest impact on member health outcomes.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Member demographics and SDOH data integrated into metrics dashboard and metric performance tracking.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Member demographics and SDOH data not displayed on clinic dashboards	Display member demographics by clinic on each clinic's performance dashboard	12/2019	Fully integrated SDOH and member demographic data displayed on individual and CHA overall performance dashboard	12/2020

Activity 3 description (continue repeating until all activities included): Support clinics and/or providers in their efforts to either increase tier levels or become PCPCH.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Status of PCPCH certification: monitor certification status for each clinic; assist non-PCPCH clinics in a readiness review to determine their capacity and ability to move forward with certification.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
3 clinics at Tier 4 6 clinics at Tier 3 1 clinic non-PCPCH	1 5 Star 2 Tier 4 6 Tier 3 1 certified at any level	12/2019	1 5 Star 4 Tier 4 5 Tier 3	12/2020

A. Project or program short title: Grieving and Appeal System Project 5: **Member Reassignment**

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

B. Primary component addressed: Grievance and appeal system

xiii. Secondary component addressed: Access

xiv. Additional component(s) addressed: Quality and Appropriateness of Care Furnished to all Members

xv. If *Integration of Care* component chosen, check all that apply:

☐ Behavioral health integration ☐ Oral health integration

C. Primary subcomponent addressed: Access: Availability of services

v. Additional subcomponent(s) addressed: Timely Access to Services

D. Background and rationale/justification:

CHA Compliance currently tracks member reassignment requests on a master spreadsheet. The process is cumbersome and does not provide adequate information to providers nor guarantee accurate tracking of the number and type of reassignment requests made by members.

E. Project or program brief narrative description:

This project will improve performance in several areas: progressive member services, enhanced provider relations, decreased number and/or duration of appeals, and improved efficiency of the reassignment process. Providers will be informed of the number of members who have asked for reassignment including the reasons for the request for purposes of improving relations with members through clinic/provider specific dashboards. CHA's Chief Operations Officer and/or Provider Network Manager will share these dashboards with providers monthly so that they will have greater awareness of member requests as they relate to their practice/clinic. Based on the criteria established by OHA that provider reassignments are identified as a grievance, all provider reassignments associated with a member's statement of dissatisfaction or provider/clinic termination of care need to be accurately captured as a grievance and reported quarterly.

F. Activities and monitoring for performance improvement:

Activity 1 description: A member-provider reassignment process will be developed to integrate and systematize 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 or ☐ Long term

Monitoring activity 1 for improvement: PCP history (Plexis and EZCAP); PCP/PCD Reassignments (change in activity or new activity); reassignments captured quarterly in Quarterly Grievance System Reporting.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No Workflow	Green Belt Project with OIT to develop workflow and system to capture 100% of all grievances	06/2019	Workflow Implementation	09/2019

A. Project or program short title: **Special Health Care Needs Project 6: Pediatric Medical Complexity and Management of Chronic, Complex Conditions**

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

B. Primary component addressed: Special health care needs

xvi. Secondary component addressed: Integration of care (physical, behavioral and oral health)

xvii. Additional component(s) addressed: Health Equity

xviii. If *Integration of Care* component chosen, check all that apply:

☒ Behavioral health integration ☒ Oral health integration

C. Primary subcomponent addressed: Access: Second opinions

D. Additional subcomponent(s) addressed: Social Determinants of Health

E. Background and rationale/justification:

Members with Special Health Care Needs are those members who have multiple chronic conditions, mental illness or Substance Use Disorders and either currently have functional disabilities or live with health or social conditions that place them at risk of developing functional disabilities. These members may need more intensive case/care management services in order to prevent their conditions from becoming worse or may need additional assistance in developing strategies to better assist them in self-management of their conditions. Of those children who are CHA members, 18% have chronic conditions; and 7.7% of CHA's total membership have special health care needs. Of CHA's total membership: 16% carry a diagnosis under the umbrella of SPMI, 33.5% have a mental health diagnosis, and 11.7% are diagnosed with Substance Use Disorder. These members represent a significant proportion of CHA's membership and could benefit from additional services in the form of either intensive case/care management and/or assistance with those social determinants of health that directly impacting their overall health.

F. Project or program brief narrative description:

CHA will focus on two of the most vulnerable populations: children with high medical complexity, and members with diabetes who have co-morbid chronic or complex conditions. These members will be identified (if not already known to our case management department) in collaboration with the Oregon Pediatric Improvement Project (through our scheduled technical assistance), data analysis of member demographics (in conjunction with Health Information Exchange and claims data), and in collaboration with CHA's network primary care providers and clinics. Members will be assigned to either CHA's internal case management, or Sky Lakes Outpatient Case Management, and staffed through the Community Care Network under development in conjunction with our work on ED utilization, with the ultimate goal being to improve member health outcomes, improve member experience with the local healthcare system, and assist members in obtaining the supports they need in order to be successful and ultimately self-manage their conditions. Best practices in Care Coordination and Case Management will be used to gauge success. Specific measures will be developed in collaboration with our community partners, providers, and clinics. Additionally, CHA is working closely

with the local Oral Health Coalition to improve dental utilization and improve health outcomes among members with diabetes through a formal performance improvement project.

G. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Identification and management of children with high medical complexity; collaboration with community partners and providers from behavioral, physical and oral health based on the member's immediate needs.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Completion of baseline documentation; meeting minutes from Community Care Network demonstrating provision of identified needs by member and demonstrated improvement of the member's health based on outcomes identified by the network team (which includes the member's care team).

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Root Cause Analysis and/or Barrier Analysis not done to identify obstacles to successful self-management	Conduct Root Cause Analysis and/or Barrier Analysis and identify improvement opportunities to make an immediate impact on member lives; written criteria and workflow established for case management assignment for both pediatric and adult populations	07/2019	Members routinely identified based on established criteria and workflow; Community Care Network sustained and demonstrated improvement in member health outcomes	12/2020 and ongoing

Activity 2 description: Intervention strategies and pilot projects for improving oral healthcare in members with diabetes developed in collaboration with the Oral Health Coalition and area providers.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Oral Health Coalition meeting minutes to demonstrate active progress toward the development of intervention strategies, pilot projects, data definitions and outcome measures; strategies documented.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Targeted intervention strategies and member outreach strategy specific to dental care not developed	Member outreach plan specific to dental care developed; intervention strategies and	09/2019	Dental outreach plan implemented including implementation of intervention strategies	12/2019

	outcome measures clearly identified			

Activity 3 description: Improve the rate of oral health assessments and preventative services received by members with a diagnosis of diabetes.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Data to demonstrate the number of members with diabetes assigned to a dental care provider, established with their assigned provider, and actively receiving preventative care.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
In 2018: 18.5% of CHA members with diabetes receiving oral health assessments; 10.6% of CHA members with diabetes have received a cleaning; and 8.6% of CHA members with diabetes have received both services	22% of CHA members with diabetes have received both an oral health assessment and cleaning	12/2019	30% of CHA members with diabetes have received both an oral health assessment and cleaning	12/2020

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.

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