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 process for developing and implementing your TQS:

Cascade Health Alliance (CHA) provides services to Oregon Health Plan members in Klamath County per its contract with the Oregon Health Authority. CHA's quality program is a matrix structure comprised of multiple departments and Committees, all dedicated to ensuring the highest quality of care is delivered timely to members, is cost-effective, and produces improved health outcomes. The Chief Medical Officer bears ultimate responsibility for the Quality Management Department, which is composed of a Director of Quality Management, a Quality Management Analyst, and a Quality Management Administrative Assistant (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. Additionally, the Quality Management Committee (a Board Committee) guides the processes and activities of quality management, performance improvement, and credentialing.

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

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, including the activities outlined in the Transformation and Quality Strategy. 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.

The Provider Network Committee is composed of directors of several CHA departments as well as Business Intelligence and compliance staff members. The Committee is charged with reviewing and approving all provider requests to become members of CHA's network, review of grievances and appeals, and review of subcontractor agreements including annual audits of those delegated functions.

The Transformation and Quality Strategy is created in coordination and collaboration with the Community Advisory Council (CAC), multiple CHA departments, and the Board Committees as outlined above. Community partners and stakeholders participate on each of the Board Committees as well as the CAC and

provide insight into issues facing our community which lead to recommendations for CHA's transformation and quality initiatives.

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

The Klamath Falls and surrounding communities' Community Health Assessment is conducted through a multidisciplinary group of community partners and stakeholders, and is led by the "Core Four": Cascade Health Alliance, Sky Lakes Medical Center, Klamath Health Partnership (FQHC), and Klamath County Public Health. A survey of community members was conducted Spring 2018 with the results informing the assessment and subsequent initiatives outlined in the Community Health Improvement Plan (CHIP). CHA's quality improvement efforts through the Transformation and Quality Strategy as well as performance improvement projects support and align with the initiatives outlined in the CHIP.

iii. 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 collaborates with many community-based organizations to ensure that initiatives designed to improve the health outcomes of our community are aligned with those put forward by the multitude of organizations within our community. By working together, CHA is better able to leverage limited resources to benefit the greatest number of individuals residing in our service area.

CHA facilitates two monthly meetings, one with administrators and primary care physicians from the community's largest clinics: Klamath Health Partnership (FQHC), Sky Lakes Primary Care Clinics, Cascades East Family Medicine, Sanford Children's Clinic, and Klamath Basin Behavioral Health (KBBH) (to facilitate the integration of the behavioral health perspective into the work of primary care as well as to facilitate the learning and involvement of the county's Community Mental Health Program in the work of the primary care providers; and the second among the community's behavioral health providers: Klamath Basin Behavioral Health (CMHP), Lutheran Community Services, Transformations Wellness Center (SUD), Best Care Treatment Services (SUD), Outpatient Care Management (Traditional Health Workers and Case Managers), and integrated behavior health providers from Cascades East Family Medicine, Klamath Health Partnership, and Sanford Children's Clinic.

In addition to these CHA-facilitated meetings, representatives from CHA's quality management department participate in the following community coalitions and service organizations: Klamath Lake Counties Coalition on Aging, Klamath Basin Oral Health Coalition, Opioid task forces (which include government and law enforcement representatives), Healthy Klamath, You Matter Klamath (suicide prevention), Soroptimist International, and the High Desert Rural Opioid Partnership. Each of these organizations provides a venue which allows CHA to participate in and impact community initiatives to improve the health and well-being of our community. CHA's quality management department also participates in Quality by Design projects led by the Sky Lakes Medical Center Performance Excellence department.

B. 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:

Klamath County is located in southern central Oregon and spans nearly 6,000 square miles with a population of roughly 67,000. The county is predominantly white (87%) and English speaking (93%). Klamath County is considered rural, and in some areas, frontier, yet boasts abundant opportunities for outdoor activities such as hiking, fishing, hunting, and birding. Klamath County is also home to Oregon's only National Park at Crater Lake. In addition to its strong partnerships with Sky Lakes Medical Center and other providers who comprise the Klamath healthcare system , CHA has established close partnerships with the two local higher education entities, Oregon Institute of Technology and Klamath Community College, to leverage limited local resources to improve the health of our community.

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

Section 2: Transformation and Quality Program Details

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

A. Project or program short title: 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. Components addressed

i. Component 1: Health equity: Data
ii. Component 2 (if applicable): Health equity: Cultural responsiveness
iii. Component 3 (if applicable): Social determinants of health & equity
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health

C. 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.

D. 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 having the greatest impact on the health outcomes of our members. Along with claims, EHR, and member file data, CHA currently utilizes Health Klamath and County Health Rankings websites to compare county-level data to CCO data. CHA is developing its data capacity to include [redacted] to provide deeper level analysis of member demographics to better inform our efforts to reach members and better meet their needs. CHA is also leveraging its partnerships with Klamath Health Partnership (FQHC) and Sky Lakes Outpatient Case Management to gather social determinants of health data on its members. The data will be used to plan and execute strategies to meet member needs, identify and reduce barriers to improved health outcomes.

During 2019, there continued to be challenges in gathering SDOH data, especially from local providers. In January of 2020, Sky Lakes Outpatient Care Management notified CHA that this data is now being entered into EPIC so that it can be easily extracted and reported. They will report this data to CHA on a quarterly basis going forward. Additionally, in 2020, CHA's Case Management department will begin using the PRAPARE tool to screen members receiving case management services for SDOH needs. Identified needs will be included in member treatment plans, and referrals made to local community benefit organizations to ensure member needs are met.

CHA's Member Services department initiated outreach to all new members within 30 days of coming onto the Plan. Focus of these efforts was educating new members on their benefits and stressing the importance of establishing care with their assigned primary care provider and primary dental care provider. This initiative has been sustained into 2020. The member handbook was updated to include a dedicated behavioral and dental health section to eliminate the need to an additional member handbook focused on these two benefit packages. This also sent a message of the importance of all three areas of health, further setting the stage for them being thought of as integrated into the healthcare system.

In 2019, the implementation of [redacted] as part of a comprehensive digital member engagement strategy was fully executed and has been successfully sustained. A workflow was established for the development and approval of all outgoing messages. Usage data has been gathered (number of texts successfully sent, opt-out rates, etc.), analyzed and improvements made as a result to the workflow. Further data elements will be collected going forward, for example, of those members who qualified for a colorectal cancer screening and received a text message reminder, how many had the screening done post-message during the measurement year.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Collect and analyze population health data on social determinants of health; use data to inform outreach, education efforts, and service needs. CHA is partnering with Klamath Health Partnership (FQHC) and Sky Lakes Outpatient Care Management to gather SDOH data from members of the community who may or may not be CHA members. Additionally, CHA Case Management department will gather SDOH data using the PRAPARE tool during member touchpoints and treatment planning to ensure that member needs are met and barriers to improved health outcomes are removed.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Integrate SDOH data into current equity dashboard and metrics performance 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	9/2019; Rev. to 7/2020	Use population health data on SDOH 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	Workflows created to allow for the collection and verification of member data provided by the OHA by Member Services through member outreach; implement use of SDOH data available on Reliance HIE.	6/2019; Rev. to 9/2020	Ongoing evaluation of the accuracy of the data provided by the OHA through member outreach; demonstrated decrease in the number of provider complaints that member level demographic data is inaccurate.	12/2019; 12/2020, etc. Integration and use of this data are ongoing efforts to inform equity work on behalf of our members.

A. Project or program short title: 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. Components addressed

a. Component 1: CLAS standards
b. Component 2 (if applicable): Health equity: Cultural responsiveness
c. Component 3 (if applicable): Social determinants of health & equity
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health

C. 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 has recently contracted with a Spanish translator who is available to translate member materials within 24 hours of item receipt.

D. Project or program brief narrative description:

Contracts with network providers require clinics to address the cultural and linguistic needs of each member. CHA offers the use of an interpreter line (Language 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 and proof of staff training at the time of initial credentialing and every three years upon recredentialing. 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. In 2019, CHA participated in technical assistance offered by the OHA to improve data collection on the use of translation services. As part of this opportunity, areas of improvement were noted and work is in progress to improve how the information is collected, analyzed, reported, and utilized to improvement members' experience.

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 the integration of our many data collection platforms, provides CHA with a better understanding of our member demographics. Along with claims, EHR, and member file data, CHA currently utilizes Health 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, as well as immediate requests by members, continues to be a key focus for improvement for 2020. In 2019, CHA contracted with an outside entity to translate all outgoing materials within 24 hours. [redacted], CHA's vendor for digital engagement, translates all text messages sent to members to the members' preferred language. Materials needed in alternative formats are provided within 48 hours of member request (large print by Koko Graphics; audio recording by Wynn Broadcasting). In 2019, CHA incorporated material specific to mental/behavioral health services and oral health services into its main member handbook, negating the need for a separate mental/dental member handbook, further streamlining information for members.

CHA is in the initial stages of implementing [redacted] community wide. [redacted] is a community web-based program which serves as a single source of information on community resources and can be filtered by language. Community based organizations can place referrals on behalf of members, in the member's preferred language, to local resources.

E. 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: Regular review of materials translated; prioritize translation based on member requests; established deadline for translation of materials following member requests.

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

80% of all active materials are translated in Spanish	Translate 100% of all member materials, including outreach and community event materials to Spanish so they are readily available upon request without a time delay.	12/2019; rev. to 12/2020;	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: Regular review of materials created in alternative formats; prioritize items based on member requests; established deadline for translation of materials following member requests.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Limited materials immediately available in alternative formats; 25% of member materials currently available in large print; 0% immediately available in audio format	Member materials immediately available upon request in alternative formats (large print, audio)	3/2020; rev. to 12/2020	Annual updates to alternative format materials	12/2021; 12/2022, etc.

Activity 3 description: 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; implementation and monthly review of utilization of [redacted] to ensure members are being referred to culturally and linguistically services and resources; data analysis to include number/type of referrals made, by agency/organization, and closed as fulfilled.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No community web-based resource portal	Implementation of [redacted]; community resources, including culturally and	12/2020	CHA website is monitored monthly to ensure resources are accurate and current; [redacted]	4/2021

	linguistically appropriate services, are uploaded to CHA's website		is widely used by 50% of community organizations for referrals to community resources; ongoing monitoring of community resources and continuous cultivation of those partnerships.	

A. Project or program short title: Project #3: Community Integrated Risk Reduction and THW Sustainable Capacity

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

B. Components addressed

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

C. Background and rationale/justification:

Increased use of Traditional Health Workers provides an important opportunity to improve the effectiveness of treatment of Mental Health (MH) Disorders, Substance Use Disorders (SUD), address Social determinants of Health and Equity (SDOH-E), decrease disparities, and reduce barriers to CLAS. Providing integrated services utilizing traditional health workers for members at highest risk reduces risk as well as Emergency Department (ED) utilization. The use of Traditional Health Workers has been proven to mitigate many of the challenges faced by high risk members through empathy, and compassionate advocacy and education.

Qualified, trained, and readily available Traditional Health Workers, Community Health Workers, and Peer Recovery Mentors are an identified gap in our community. Identified candidates must travel outside of the community to receive training and mentoring, often at a high cost to the employing agency/organization or the peer him/herself. CHA is actively pursuing partnership and curriculum development with [redacted] to implement a training program for Traditional Health Workers.

D. Project or program brief narrative description:

This project is two-fold and will address several needs in the community: intensive case management of high-risk members; and establish a formal training program for Traditional Health Workers.

High risk members are defined as those with multiple comorbidities, including medical (chronic diseases) and/or behavioral and substance use disorders, as well as frequent ED utilization. Members will be identified using predictive analytics platforms and will focus on members diagnosed with a SUD, SPMI, and at least one of the following chronic diseases: diabetes, congestive heart failure, chronic obstructive pulmonary disorder, or asthma. The identified cohort will be assigned a case manager for intensive case management and the development of a treatment plan to establish a baseline health record identifying factors that will be mitigated through an integrated intervention model. Interventions

will consist of referrals to and engagement with SUD and BH treatment (co-occurring disorders), medication review and monitoring for adherence, access to appropriate medical and behavioral health services, and engagement in wellness practices, all activities being supported by a Traditional Health Worker, Community Health Worker, SUD Peer Support Specialists, and Peer Recovery Mentors.

CHA will increase the Traditional Health Worker capacity in our community through the development and implementation of a training curriculum and program in collaboration with [redacted]. This program will allow for the training and mentoring of prospective peers within our own community, lessening the financial burden of travel to other communities outside our region for training, and build capacity within our own community.

Together, this project is designed to decrease the overall ED utilization rate among members within the targeted high-risk cohort.

E. Activities and monitoring for performance improvement:

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Identify targeted cohort; establish treatment targeted and individualized treatment plans.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Cohort not identified	Initial cohort identified; continuously updated to reflect new data	4/2020	Cohort identified; continuously updated	Initial cohort identified by 4/30/2020; continuously updated as needed
Cohort identified	Establish treatment plan with identified, targeted interventions	6/2020	Treatment plans created for each identified cohort member and reviewed semi-annually	Treatment plans continuously monitored and revised 12/2020, 12/2021, etc.

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

☐ Short term or ☒ Long term

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

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

Cohort metrics not identified	Identify targeted cohort metrics to gauge performance	4/2020	Metrics aggregated, reviewed and analyzed monthly.	7/1/2020

Activity 3 description: Increase community capacity of THW/CHW/Peer Recovery Mentors/Support Specialists through curriculum development, execution of program; create mechanism for sustainability of education and certification program.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the number of both newly certified and continued service independent and clinic associated THW/CHW/Peer Recovery Mentors/Support Specialists.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Curriculum/Program not created	Curriculum/Program created, approved by [redacted]; students enrolled	9/2020	Successful completion of the program, including certification and employment, of the Program's first cohort	9/2021

A. Project or program short title: Project #4: Oral Health Care Coordination for Vulnerable and At-Risk Populations

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

B. Components addressed

a. Component 1: Oral health integration
b. Component 2 (if applicable): Special health care needs
c. Component 3 (if applicable): Utilization review
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health

C. Background and rationale/justification:

Members with Special Health Care Needs (defined as members with 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), especially those with diabetes, tend to be under-utilizers of oral health care services despite being assigned to an oral health provider. Diabetes greatly increases the risk of developing oral infections, including periodontal disease, especially when uncontrolled. Periodontal disease can make it more difficult to control an individual's blood glucose level. Diabetes can also lead to dry mouth and thrush.

Additionally, pregnant women are under-utilizers of oral health care services while pregnant due to misconceptions about the safety and/or appropriateness of care during pregnancy. A mother's oral health status is a strong predictor of her children's oral health status. Not tending to oral health hygiene can lead to gingivitis increasing the risk for caries. In addition to promoting good oral health care habits, proper oral hygiene during pregnancy reduces the transmission of bacteria that cause caries from mothers to infants and young children.

Within our health community, interoperability of electronic health records creates a challenge to full integration of the healthcare system, particularly among the dental community. The majority of providers continue to utilize fax machines to send referrals and communication to providers outside of their clinics and individual practices. Also, electronic health records are not widely used by oral health providers due to the high cost associated with implementation.

D. Project or program brief narrative description:

This oral healthcare project will focus on two of the most vulnerable populations: members with diabetes who have co-morbid chronic or complex conditions, and members that are pregnant. Members will be identified, if not already known to our case management department, through data analysis of member demographics (in conjunction with Health Information Exchange and claims data), and in collaboration with CHA's network of primary care providers, clinics, obstetric providers, and oral health providers. Members will be assigned to either CHA's maternal case management department, oral health case manager, or Sky Lakes Outpatient Case Management, and staffed through processes identified at each entity for review and coordination of member care. CHA's maternity case manager is notified of all newly pregnant members and follows their health status throughout their pregnancy, postpartum period, and the first few months of the child's life, connecting mothers and families with needed resources and ensuring all maternal and infant preventive services are completed.

In addition to the Oral Evaluation in Members with Diabetes incentive metric, specific measures will be developed in collaboration with our community partners, providers, and clinics. This work will be facilitated and coordinated through CHA's participation in the Klamath Basin Oral Health Coalition (KBOHC; a local community-based collaborative dedicated to improving dental utilization and improve health outcomes among members with diabetes) through a formal performance improvement project. The project's focus is to develop a robust, multi-disciplinary educational campaign to address misconceptions in the community about oral health care. Unified messages created by a local obstetrician and dentist regarding the safety of oral health care during pregnancy will be created and shared with all providers and provider types in the community and used for direct education with members. Additional educational materials will be created with messaging about oral health care and diabetic care to be distributed in primary care offices, dental offices, public health, DHS, and additional community-facing organizations.

In addition to educating the public, KBOHC promotes oral health care trainings for frontline healthcare workers, i.e. DHS family coaches and community health workers. The Oregon Health Sciences University senior nursing students at Oregon Institute of Technology have begun utilizing the Smiles for Life program to train family coaches. Work is being done to integrate the Smiles for Life program into the training curriculum for community health worker certification and the medical assistant certification at [redacted]. Additionally, the OHSU Nursing program at OIT works closely with OIT's Dental Hygiene program and Klamath Basin Behavioral Health to coordinate care in the integrated health settings in which students work (i.e. Cascades East Family Medicine – integrated behavioral health; Klamath Health Partnership – integrated behavioral, physical, and oral healthcare).

As part of this project, CHA contracts with a [redacted], to provide preventive dental services to school age children in all Klamath County and Klamath Falls City Schools. The services offered by [redacted] will be expanded to include pregnant women, mothers, and young children at Public Health in the WIC program, and adults through four community outreach events per year (Free Dental Days) in partnership with Klamath Health Partnership (FQHC). Community outreach will be expanded in the second year of the project to include two rural communities within CHA's service area and outside the local Klamath Falls area.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Implementation of intervention strategies and pilot projects identified in the KBOHC Work Plan, including data definitions, outcome measures, and documented strategies to increase the number of members visiting their assigned oral health provider annually. Please see attached KBOHC Work Plan.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitoring data points indicating successful execution of the KBOHC Work Plan; monitoring conducted at monthly KBOHC meetings, new strategies developed based on improvement opportunities noted during data review and analysis.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Of the 88% of CHA members who are assigned to a primary care dentist, only 39.5% have been seen by their assigned oral health provider.	50% of members seen by their assigned oral health provider	12/2020	75% of members seen by their assigned oral health provider	12/2021

Activity 2 description: Increase awareness and education of members of the relationship between oral health and physical health according to the strategies in the KBOHC Work Plan

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitoring of data points quarterly; demonstrated increase in utilization of preventive dental services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Low percentage of members who have received an oral health evaluation and/or cleaning within the current year (2019: 50.9% with an evaluation; 32.7% with a cleaning; *27.6% with both services*).	50% of members have received an oral health evaluation **and** cleaning in the measurement year.	12/2020	75% of members have received an oral health evaluation **and** cleaning in the measurement year.	12/2021
Community outreach occurring once per year (Free Dental Days)	Community Outreach (Free Dental Days) four (4) times per year.	6/2021	Community outreach expanded to two outlying rural communities within CHA's service area; two (2) Free Dental	6/2022

			Days in both locations per year	

Activity 3 description: Increase the number of pregnant women obtaining oral health care during pregnancy through the education of both providers and pregnant women of safe and appropriate oral health care during pregnancy through collaboration and coordination with both physical and oral health providers.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Monitoring of data points quarterly; demonstrated increase in utilization of preventive dental services among pregnant women.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
In 2019, 17% of women received oral health care during pregnancy	30% of women received oral health care during pregnancy	12/2020	50% of pregnant members received oral health care during pregnancy	12/2021
No oral healthcare services offered at Public Health for pregnant women, mothers, and young children.	Contract established to provide oral healthcare services to pregnant women, mothers, and young children at Public Health.	9/2020	Oral healthcare services provided to pregnant women, mothers, and young children two full days per month at Public Health.	12/2021

Activity 4 description: Increase the rate of oral health assessments and preventive dental services received by members with a diagnosis of diabetes.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Data to demonstrate the number of members with diabetes assigned to an oral health care provider, established with their assigned provider, and actively receiving preventive care.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
96% of members with diabetes who have an assigned oral health care provider	98% of members with diabetes are assigned an oral health care provider	9/2020	100% of members with diabetes are assigned an oral health provider	3/2021
26.1% of members with diabetes who have an established relationship with their PCD (primary care dentist) as	32% of members with diabetes have an established relationship with their assigned PCD	12/2020	40% of members with diabetes have an established relationship with their PCD	12/2021

evidenced by a screening or cleaning within the measurement year				

A. Project or program short title: Project #5: Member Reassignment

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

B. Components addressed

a. Component 1: Grievance and appeal system
b. Component 2 (if applicable): Access: Quality and adequacy of services
c. Component 3 (if applicable): Access: Timely
d. Does this include aspects of health information technology? ☐ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health

C. Background and rationale/justification:

CHA Compliance currently tracks member reassignment requests, as they relate to member grievances, on a master spreadsheet. The data in this section of the spreadsheet includes all grievances received by CHA. The process of tracking resolution is cumbersome and does not include all reassignments. This master spreadsheet does not currently reference all provider dismissals of members that ultimately result in reassignment. Dashboards are created from the information that is contained in this spreadsheet. All provider dismissal notifications are not being sent to CHA, so not captured in our internal database, and therefore do not appear on provider dashboards. As a result, recipients of the dashboard, whether internal CHA departments or providers, are not guaranteed to receive complete number and type of reassignments. Of more concern, members are not being reassigned timely which has the unintended consequence of either emergency department utilization due to a lack of an established relationship with a primary care provider, or a hasty assignment to a provider who may not meet the cultural and linguistic needs of the member.

D. Project or program brief narrative description:

This project will improve performance in several areas: progressive member services, enhanced provider relations, and improved efficiency of the reassignment process due to provider dismissal. Providers will be informed of the number of members who requested reassignment for all areas of grievances, including dismissals from care. Inclusion of provider dismissals and the resulting reassignments will improve relations with providers and members through clinic/provider specific dashboards. CHA's Chief Operations Officer and/or Provider Network Manager will share these dashboards with providers monthly to enhance provider awareness of member reassignments 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.

E. Activities and monitoring for performance improvement:

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

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PCP history ([redacted]); PCP/PCD Reassignments (change in activity or new activity); reassignments captured quarterly in the Quarterly Grievance System Report.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No policy for Notification of Member Dismissal and Reassignment	Policy created to include provider responsibility of notifying CHA of member dismissal; and timelines established for member reassignment	4/2020	Providers trained in new policy; process sustained over time with 95% accuracy	5/2020
Providers not notifying CHA of member dismissal and need for reassignment	Providers notifying CHA of all member dismissals within timeframe established in policy	5/2020	Process sustained over time with 95% accuracy	12/2020
Member Services not reassigning members who have been dismissed timely due to not being notified of dismissal	Members Services reassigns members within the timeframe established in policy; outreach calls and letters made to members about their reassignment	5/2020	Processed sustained overtime with 95% accuracy	12/2020

Activity 2 description (continue repeating until all activities included): Grievance log and monthly provider performance dashboards will be inclusive of both member and provider driven reassignment requests. The data will integrate all reassignment resolutions and further systematize the process of reassigning members. Reassignment resolutions, whether related to complaints about provider services or dismissals from care, will be tracked, and all parties notified of the change in a timely and consistent manner.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: PCP history ([redacted]); PCP/PCD Reassignments (change in activity or new activity); reassignments captured quarterly in the Quarterly Grievance System Report.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No standardized template for Dismissal of Care letter	Standardized template for Dismissal of Care letter created for provider use	4/2020	Dismissal of Care template in consistent and sustained use	6/2020

No workflow for member reassignment due to provider dismissal	Create workflow for member reassignment per Provider Dismissal Advisement	5/2020	Workflow created and in consistent and sustained use	7/2020
No training established for provider and/or staff education on Dismissal of Care process	Create education curriculum and training for providers regarding Dismissal of Care process and expectations	6/2020	Providers and staff trained in Dismissal of Care process and expectations	9/2020
No Tracking of efficiency of process for members being dismissed from care by providers	Dismissal of Care being tracked according to established workflow	6/2020	Detailed reassignments due to Dismissal of Care are included and tracked in the Master Grievance Log	6/2020

A. Project or program short title: Project #6: Meaningful Access to Interpretation and Translation Services

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

B. Components addressed

a. Component 1: Access: Cultural considerations
b. Component 2 (if applicable): Patient-centered primary care home
c. Component 3 (if applicable): Health equity: Cultural responsiveness
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☒ Social and community health

C. Background and rationale/justification:

Klamath County, like many rural communities, suffers from a severe workforce shortage of healthcare professionals. This includes but is not limited to certified Medical Interpreters. CHA's workforce is reflective of this shortage in that while it employs several Spanish-speaking staff members, none are certified interpreters or translators. This is also true of CHA's network of providers. Professional medical interpreters reduce the risk of misdiagnosis, inadequate informed consent, and ensure proper understanding of treatment plans. Klamath County's second largest population group by race and ethnicity is Hispanic or Latino individuals and families. The Hispanic or Latino population has experienced the most growth, increasing from 10% in 2010 to 12% of the County's population in 2017. Of these individuals, 8% do not speak English. According to the Oregon Health Care Interpreter Registry, there are only two registered medical interpreters in Klamath County. The shortage of certified medical interpreters is a social and environmental disadvantage for many individuals resulting in a potential health disparity. This

shortage is caused, at least in part, by the lack of an existing formal health care interpreter training program in the county.

CHA utilizes multiple venues to collaborate with its provider network and Community Based Organizations to develop culturally appropriate services for its members, and the community as a whole. CHA also provides technical assistance to its provider community to further develop PCPCH capacity. One area in which such collaboration and technical assistance has proven challenging is the limited capacity of certified interpreters available for members and providers.

CHA participates in the regional Health Information Exchange, Reliance eHealth Collaborative. This tool allows for community providers and clinics the capabilities to share SDOH-E data captured to become part of the member's overall electronic health record. This information is available to participating providers and clinics when delivering services to members. CHA is partnering with multiple community-based organizations to implement a Community Information Exchange (CIE) ([redacted]) in Klamath County through its partnership with Healthy Klamath (www.healthyklamath.org), go-live date scheduled for August 21, 2020. This platform has a closed-loop referral system to address member SDOH-E needs as well as housing a database of available community resources. The site is available in Spanish, the most prominent language spoken in CHA's service area after English.

In 2020, CHA's provider network is expected to collect and report on member SDOH needs, including needs not currently addressed by community resources and report the information to CHA. CHA uses this information to identify needed community resources for development. Through this process, CHA has already identified the need to develop an academic curriculum to certify medical interpreters.

D. Project or program brief narrative description:

A growing body of documentation and research proves that certified medical interpreters contribute to the prevention and/or alleviation of health disparities among non-English speaking populations. In partnership with [redacted], CHA will develop and implement an academic program at [redacted] that trains and certifies current and new Spanish interpreters for our community. The course will consist of a 156-hour training which prepares bilingual individuals to serve as healthcare interpreters and meets the qualifications of the Oregon Health Care Interpreter Law standards for training and education of interpreters. The course will be delivered in a blended format including online instruction, classroom instruction and clinical practicum. The course will follow the formal training and work experience requirements set by the Oregon Health Authority Training Standards identified in OAR 333-002-006.

An additional component of this project is to have a CHA staff member certified as a Spanish Interpreter/Translator through Rogue Community College's program (in neighboring Jackson County) or another OHA approved course while the program at [redacted] is being developed. CHA will also provide technical assistance to its provider network, particularly PCPCHs, to have staff members trained and certified. Not only will having certified interpreters provide much needed culturally appropriate services to members seamlessly in the same office/clinic and will contribute to our current 4 Star PCPCH providers to move to a 5 Star designation.

As part of its Language Access Plan, CHA will monitor the use of its community translators/interpreters through its language access service, as well as monitor the use of its internal and provider certified staff in working with Spanish speaking members. Data collected will become part of CHA's Equity dashboard and

be used to identify and direct improvement opportunities and future projects. CHA will work with its provider network to in developing the infrastructure to report the utilization of translator/interpreter services by provider/clinic.

E. Activities and monitoring for performance improvement:

Activity 1 description (continue repeating until all activities included): Increase community capacity of Medical Spanish Interpreters through curriculum development and execution of an academic program for certification through [redacted].

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor curriculum development, approval process, and execution of the academic program at [redacted].

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No curriculum/course for interpreter program	Curriculum/academic program developed	9/2020	Curriculum/program approved by OHA	02/2021
No students enrolled in interpreter program	12 students enrolled in first cohort of interpreter program to begin Spring term 2021	3/2021*	80% of students enrolled complete the program	09/2021*
No students certified as translators/interpreters	Students completing the program pass the certification exam, including submission to the Oregon registry of certified interpreters	09/2021*	90% of Certified interpreters are employed in Klamath County	12/2021*
Academic program not replicated	Second cohort of students successfully completes the program	6/2022*	Program is successfully sustained	6/2023*

***Timelines dependent on Covid-19 response and ability of [redacted] to offer online courses.**

Activity 2 description: CHA staff become certified translators/interpreters.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Ensure staff are selected for certification, successfully complete the program, and become a certified interpreter.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No CHA staff are Certified Interpreters	1 CHA staff members successfully completes the	12/2021*	2 CHA staff members successfully	12/2022*

	training program through Rogue Community College or other OHA approved training program		become Certified Interpreters and submits to the Oregon registry	

***Timelines dependent on Covid-19 response and ability of [redacted] to offer online courses.**

Activity 3 description: Establishment of a data collection and review process

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Ensure internal and provider data collection systems for interpreter utilization meet Health Equity: Meaningful Language Access measure specifications, data is validated and analyzed for use and improvement opportunities at a regularly established accountability cadence.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No system for tracking and monitoring utilization of internal translation and interpreter services provided by CHA staff for members seeking assistance from CHA.	Data collection system established for internal utilization of translation and interpreter services.	12/2020	Utilization data gathered and monitored monthly through sustained process.	06/2021
No system for gathering translation and interpreter services provided to CHA members in clinics/offices within CHA's provider network via CHA's Language Line vendor.	Data collection system established for tracking utilization of interpreter/translator services provided to CHA members in clinics/offices within CHA's provider network via CHA's Language Line vendor.	12/2020	Utilization data gathered and monitored monthly through sustained process.	6/2021
No system for gathering translation and interpreter services provided to CHA members by provider staff and/or clinic-provided interpretation services.	Data collection system established for gathering translation and interpreter services provided to CHA members by provider staff and/or clinic-provided interpretation services.	9/2021	Interpretation/translation services provided by provider staff and/or clinics reviewed and monitored monthly through sustained process.	1/2022

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 16 to CCO.MCODeliverableReports@state.or.us.