2022 Quality Improvement Program

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Samaritan Health Plans

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Executive Summary

Samaritan Health Plans (SHP) is an integrated nonprofit healthcare organization that includes InterCommunity Health Network-Coordinated Care Organization (IHN-CCO). IHN-CCO serves Oregon Health Plan members in Linn, Benton, and Lincoln counties. SHP serves Medicare through Samaritan Advantage Health Plan, HMO (SAHP) and Special Needs Plan (SNP) members in Linn, Benton, and Lincoln counties. SHP also serves Samaritan Health Services (SHS) employees through a self-funded plan Samaritan Choice Plans (SCP). SHP also offers large, small, and association Employer Group (Commercial) Plans.

As of December 2021, SHP serves approximately 93,870 members under these lines of business.

The Quality Improvement (QI) Program encompasses Population Health Management and describes organizational framework, scope, and objectives for improving the safety, quality, experience, and affordability of healthcare for our members. The QI Program provides an overview of the objectives, structure, responsibilities, and program components, and activities in place to monitor and improve the quality of health care services and the outcomes of care. The QI Program is updated annually to respond to the changing needs of members, clinical standards, and regulatory and accrediting standards.

MISSION Building healthier communities together
VISION Serving communities with PRIDE
VALUES **P**assion * **R**espect * **I**ntegrity * **D**edication * **E**xcellence

Program Overview

The Samaritan Health Plans and IHN-CCO Board of Directors govern the QI Program, which integrates network providers, social service agencies and community-based organizations, members, health plan departments and staff at all levels. The QI Program ensures members receive compassionate and effective care that is easily accessible, safe, equitable and affordable.

Purpose

The QI Program provides a formal process to monitor and evaluate the quality, appropriateness, efficiency, safety, and effectiveness of care and services using a multidimensional approach objectively and systematically. This approach enables SHP to focus on opportunities for improving operational processes and health outcomes, ensuring cultural and linguistically appropriate services and high levels of member and clinician and care team satisfaction. The QI Program promotes accountability of all staff and affiliated health professionals and community-based organizations for the quality of care and services provided to our members.

Quality Improvement Goals

The SHP QI Program goals aim to improve the quality of health care while advancing health care transformation through the Quadruple Aim of Healthcare by optimizing health and wellbeing with a focus on safety, increasing affordability, engaging care teams and partners, and enhancing the care experience.

- **Deliver quality care and services that set community standards.** Maintaining processes to ensure evidence-based clinical practice guidelines are adopted, regularly reviewed, approved, and disseminated to network providers. Systematically evaluate delivery of services in accordance with approved guidelines and clinical performance indicators.
- **Give members care that is compassionate and effective.** Integrating behavioral health, addressing the whole person including social determinants of health and health equity, individualizing care, engaging in health promotion and education of preventive services and active self-management.
- **Exceed members' expectations of care.** Actively monitoring member perception of network providers and their health outcomes to identify trends and opportunities for quality improvement through member experience feedback and CAHPS (Consumer Assessments of Healthcare Providers and Systems) and HOS (Health Outcomes Survey).
- **Engaged and aligned provider network.** Building relationships and engaging clinicians in quality improvement work that is physician-led, evidence-based, and data driven.

Objectives

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement.
- Meet the cultural and linguistic needs of the membership.
- Comply and coordinate with all governmental agency requirements.
- Support clinicians with participation in quality improvement initiatives of SHP and all governing regulatory agencies.
- Establish clinical and service indicators that reflect the demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Measure the availability and accessibility to clinical care and services.
- Measure member satisfaction to identify and address areas of dissatisfaction in a timely manner through quarterly analysis of trended member compliant data, member satisfaction surveys, and member suggestions to improve care and services.
- Continue to review, adopt, and adapt practice guidelines reflective of the membership.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Oversee delegated activities by establishing standards, monitoring performance, and evaluating performance annually.
- Evaluate over and underutilization, continuity, and coordination of care through a variety of methods and frequencies based on member needs.
- Coordinate all QI activities with all other activities, including the identification and reporting of risk situations, the identification and reporting of adverse events from UM activities, and the identification and reporting of quality-of-care concerns through monitoring reports, and complaints and grievances.

- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include identification of high-risk and/or chronically ill members, education of clinicians, and outreach programs to members.
- Create and maintain infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting bodies as appropriate.

Evaluation of the QI Program

The QI Program is evaluated on an annual basis. Findings from the annual evaluation are used to make modifications to the QI Program and QI Workplan, as necessary.

Scope of the QI Program

The QI Program provides for review and evaluation of all aspects of health care, encompassing both clinical care and services provided to members. All departments participate in the quality improvement process. The Chief Medical Officer integrates review and evaluation components to demonstrate the process is effective in improving health care. Measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process. The scope of the quality review will be reflective of the health care delivery systems, including quality of clinical care and services. All activities will reflect the member population in terms of age groups, disease categories, special needs, risk status, including those members with complex needs.

The scope of services includes services provided in institutional settings, such as acute inpatient, outpatient, long term care, skilled nursing, ambulatory care, home care, and behavioral health, and services provided by primary care, specialty care and other practitioners.

QI Program Structure

Oversight of the QI Program is provided through a committee structure, which allows for the flow of information to and from the SHP and IHN-CCO Boards of Directors.

QI PROGRAM FUNCTIONAL AREA AND RESPONSIBILITY

The Quality and Population Health Department is responsible for implementing a multidimensional and multidisciplinary QI Program that effectively and systematically monitors and evaluates the quality and safety of clinical care and services rendered to members.

QI PROGRAM FUNCTIONS

- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services in primary care delivery sites.
- Ensure effectiveness of continuous quality improvement activities across the organization.
- Evaluate the standards of clinical care and promote the most effective use of medical resources while maintaining acceptable and high standards. This includes annual evaluation of the QI Program.
- Improve health care delivery by monitoring and implementing corrective action, as necessary, for access and availability of provider services to members.
- Conduct oversight of delegated providers.
- Ensure strong collaboration between QI and other SHP departments, such as Care Coordination, Pharmacy and Provider Services, as needed, to ensure the most effective action plan is being taken on various QI initiatives.

QUALITY AND POPULATION HEALTH DEPARTMENT

The Quality and Population Health Department reports to the Chief Medical Officer. Responsibilities of the department include:

- Provide staff support to the Quality Management Council, the Quality Improvement Committee, and the Quality-of-Care Review Committee.
- Develop initial drafts of QI Program documents for committee review and approval.
- Develop a workplan identifying the responsibilities of the operations that support the QI Program implementation.
- Review and evaluate the workplans and quarterly reports of committees and taskforces.
- Assist in the review and evaluation of delegate reports.
- Assist in the data collection for selected components of contractual reporting requirements for external review agencies.
- Assist and implement systematic data collection methodologies.
- Assist in the development of project design and methodologies for disease management and health promotion programs.
- Monitor the QI Program to assure compliance with regulatory and accrediting requirements.
- Assist in the development of organizational policies related to Quality Improvement.

THE QI PROGRAM IS COMPRISED OF THREE CORE SECTIONS:

- **Clinical Care and Patient Safety**
  Clinical care refers to all clinical care and services provided to members as well as the clinical programs to manage populations. In the context of clinical care, patient safety refers to the efforts of clinical providers to reduce or avoid preventable harm to the patient during treatment, as well as strategies to keep patient health risk as low as possible.
- **Quality and Service Improvement**
  The Quality and Service Improvement section includes quality improvement initiatives to improve care and services.
- **Quality Governance and Systems**
  The Quality Governance and Systems section includes committee structures, roles and responsibilities, quality information systems and quality data reporting, Health Equity, Delegation and Oversight, Program Audits, the QI Workplan and confidentiality and security of information.

The QI Program provides the organizational objectives, structure, program components, processes, and quality improvement tools to carry out the quality management and population health goals for the membership. Regulatory requirements for the QI Program are reviewed annually to ensure compliance.

The QI Program is available to members and providers upon request.

Quality Definition

At SHP we define healthcare quality by the Institute of Medicine six aims. Care that is safe; effective; patient-centered; timely; efficient; and equitable.

Quality Improvement Focus Areas

The QI Program includes the following:

- Accreditation & Standards
    - Planning and implementation of policies, procedures, and requirements
    - Quality assurance and monitoring to ensure adherence to standards
    - Oversight of NCQA Population Health Management Standards
    - Evaluation of adherence to NCQA standards
    - Regulatory, accreditation, and external reporting
    - Reportable events
    - Ethics
- Population Insights
    - Population Assessment
    - Data management systems, data collection plans, data validation, data display
    - Maintaining data security and confidentiality
    - Statistics for data description
    - Interpreting data to support decision making
    - Epidemiology theory and surveillance
    - Measures, metrics, and scorecards
- Continuous Quality Improvement
    - Establishing priorities
    - Developing action plans
    - Performance improvement methods, tools, and technical resources
    - Change management
    - Process improvement teams
    - Performance improvement plans
    - Project management, closure, and program handoff
    - Evaluation
- Patient Safety
    - Culture of Safety
    - Alignment with SHS on Patient Safety
    - High Reliability Organization, Just Culture, and Patient Safety Principles
    - Program Implementation
    - Developing corrective action plans
    - Technology and resources
    - Audits and evaluation
    - Risk management

Clinical Care and Patient Safety

The Clinical Care and Patient Safety section of the QI Program encompasses all clinical care and programs, including population health management, Health Education and Promotion, Clinical Practice Guidelines, Behavioral Health Program, Care Management Program, Pharmacy Services, Continuity and Coordination of Care, and Patient Safety.

Population Health Management

Population Health Management Definition

The Population Health Alliance defines Population Health Management (PHM) as "a model of care that addresses individual's health needs at all points along the continuum of care, including in the community setting, through participation, engagement, and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost effective and tailored health solutions."

A large focus of our QI Program is Population Health Management (PHM). PHM requires data and analysis to determine the needs of the population and to ensure members are provided evidence-based high-quality care across the continuum of care. The PHM continuum includes acute and chronic care management, preventive care, early intervention, and wellness. SHP is implementing a comprehensive population assessment, data aggregation and risk stratification process for health plan products. Hierarchical Condition Categories (HCCs), claims data, lab data and health risk assessment data are used to stratify and segment member populations into risk groups or cohorts so that interventions can be matched to member needs. Cohorts are defined within member populations to match interventions to individuals within the cohort to improve the health and well-being of the population while keeping care affordable. Cohorts are tracked and monitored for care gaps, and SHP engages with community agencies, stakeholders, care management vendors and primary care providers to develop a collaborative plan of action.

The PHM process is a continuous cyclical process beginning with defining the population, identifying care gaps, stratifying risk, engaging providers, and patients, managing care, and finally measuring the outcomes. The QI Program's PHM strategy focuses on putting the member/population at the center to implement targeted interventions that will improve members' health and population health outcomes.

In 2021, the Quality and Population Health Department conducted a population assessment and, considering member characteristics, social factors, disease prevalence, and the unique regional environments, identified three

priority areas: diabetes, hypertension, and high-risk pregnancy. The QI Program is not limited to these focus areas; however, they are prioritized to improve health care outcomes and while doing so, also reduce costs.

Population Insights

The population assessment is key to both defining the population and measuring member health outcomes. The objective of the population assessment is to understand our population and population needs, and evaluate the care and services provided to our members. The SHP Population Insights (PI) Program includes a data management plan to ensure quality control of data collection and processes, data security, integrity of data and analysis and confidentiality of data. The Population Insights Program is focused on the ongoing tracking of clinical quality and performance and developing actionable data to improve health outcomes. The PI Program initiatives and program activities allow SHP to determine the quality of care and identify areas for improvement.[i]

In 2020 SHP contracted with the Population Health Management Platform Arcadia Analytics. With the addition of this information system SHP will be able to aggregate disparate health data to drill down on the unique complexities of its membership and populations. The Arcadia platform will drive quality improvement and the SHP value-based care strategy by surfacing actionable opportunities to leverage comprehensive change through improved care coordination and further informed provider contracting and relationships.

Health Education and Promotion

SHP Health Education and Promotion activities and materials are reviewed annually to ensure alignment with best practice, clinical guidelines, and contractual and regulatory requirements and to ensure the program is tailored to specific age groups and population health needs.

Health education and promotional materials are developed through various means keeping the needs of the member population in mind. They are provided in English and Spanish as requested or required. Health education and promotional materials are often created in support of the various quality projects and initiatives. The quality team continues to develop Health Tips member newsletters, brochures and flyers, targeted letter and postcard mailings, Lunch and Learn events, CCO metrics training focused on child growth, annual wellness visits, and developmental screenings. The SHP health resources webpage links are reviewed and updated to include the SHS library and external resources to expand member access to health-related materials and education. [ii]

Evidence-Based Medicine and Clinical Practice Guidelines

SHP evaluates practice guidelines, standards and policies for dental care, medical and behavioral health practice to ensure alignment with evidence-based practice, community standards and relevant law. The QMC reviews, adopts, and disseminates evidence-based clinical practice guidelines. Clinical practice guidelines (CPGs) are reviewed and updated at least every two years or as needed to reflect current standards and scientific knowledge. Clinical practice guidelines encompass acute, chronic, and preventive care relevant to the SHP membership. CPGs are available to community clinicians, network providers and members. To evaluate delivery of services in accordance with approved guidelines, annual performance measurements are analyzed using claims data, lab data, and electronic health record (EHR) data.[iii]

Accreditation & Standards

SHP Quality and PHM programs, including the Special Needs Plan Model of Care (SNP MOC), ensure compliance with NCQA accreditation and regulatory standards through “audit readiness” activities. Policies and procedures

and reporting guidance are reviewed and updated no less than annually to maintain compliance with current regulatory requirements and address identified gaps in procedures. Performance of internal programs and external programs and services across the continuum of care and provider network are measured against CMS and OHA contract requirements, as well as federal and state regulations. Mock-audits with delegated entities are completed as a means of evaluating performance and compliance in accordance with applicable state and federal requirements and NCQA standards. Integrity of the patient safety program is monitored through the review of clinical practice guidelines, reportable events, and ethics.

Behavioral Health Program

Behavioral health services are provided by an extensive network of behavioral health providers and facilities. This includes inpatient psychiatric and substance abuse units as well as free-standing psychiatric and substance abuse facilities. Outpatient care is provided by psychologists, psychiatrists, psychiatric nurse practitioners, social workers, and licensed mental health counselors and traditional health workers (THW). Treatment is also provided in community mental health clinics and substance abuse programs. In addition to standard inpatient and outpatient behavioral health services, SHP has contracted with providers to develop both telephonic and mobile crisis intervention. All providers meet state requirements for licensure as well as SHP credentialing standards.

The Behavioral Health Director provides oversight of the Behavioral Health program and is involved in implementing and evaluating behavioral health services. Triage and referral processes for behavioral health services are coordinated through qualified behavioral health care managers. Referrals to intensive levels of care are facilitated through contracted community mental health crisis response teams and qualified licensed practitioners. The program oversees services such as Assertive Community Treatment (ACT), Wraparound, intensive care coordination, and care management for adults, youth, and children.

SHP assesses population needs to identify gaps in community behavioral health services. By partnering with local behavioral health providers and developing innovative programs these gaps can be addressed.[iv]

Care Management Program

Care Management

The Care Management (CM) program offers support and assists members who are experiencing immediate and ongoing medical conditions or injuries that may require complex, high-intensity, long-term and/or a high utilization of health care services. Members may be identified for care management through referrals, diagnosis of specific conditions, risk stratification and/or quality improvement initiatives. The CM program uses data and analytics to assess member needs and develop strategies and approaches to engage members to achieve their health care goals. The objective of care management is to ensure appropriate, timely, effective, and continuous person-centered care that improves health outcomes and maintains the highest level of function. Care management includes working with hospitals, facilities, community partners and any member of the Interdisciplinary Care Team, to meet the individual member's care needs. Care management staff perform services in a trauma-informed manner, understanding the impact of trauma on an individual's ability to function, interact with others, and request and accept help.[v]

Complex Case Management

Complex Case Management (CCM) is a process designed for members with chronic and/or complex medical/behavioral health conditions to promote independence, optimal health, and continuity of care at the

lowest cost appropriate to the member's needs. The CCM program is voluntary and is provided at no cost to the member. A member must give verbal and/or written consent for enrollment in this program. The program is most successful with participation of the member's family, caregivers and/or other support systems. The CCM program is a delegated service provided through AxisPoint Health and is available to any individual enrolled into IHN-CCO, Samaritan Commercial and Advantage Health Plans, including Special Needs Plan.[vi]

The following conditions are examples of diagnoses that are commonly identified for case management:

- Complex psychosocial conditions
- Congestive Heart Failure (CHF)
- Diabetes
- High-risk pregnancy
- Physical Trauma

Maternity Case Management

SHP offers a case management program specifically tailored to the needs of a woman identified as having a high-risk pregnancy. SHP case management and public health departments are working collaboratively to include data to identify high-risk pregnant members in the first trimester of pregnancy.

Intensive Care Coordination for Members with Complex and Special Health Needs

Intensive Care Coordination (ICC) is a process to coordinate multiple services and supports available to members who have complex medical, dental and/or behavioral health needs that may include multiple chronic conditions and/or severe and persistent behavioral health challenges. ICC facilitates communication between members, providers, and community partners through interdisciplinary care teams to address health disparities, assist in accessing appropriate preventive, remedial and supportive care, and services, and manage transitions and gaps in care to improve outcomes.

IHN-CCO currently serves more than 74,000 Medicaid managed care enrollees. While many of these members are healthy and require only access to primary care practitioners to obtain episodic and preventive health care, the Medicaid program also serves several population groups who have complex medical, behavioral, and long-term care needs that have poorer health outcomes and drive high-cost services, including inpatient and long-term institutional care. Navigating the current health care system can be difficult for these members. Encouraging the appropriate utilization of services, through ICC and service integration, is essential for controlling future health care costs and improving health outcomes for this population.[vii]

Continuity and Coordination of Care

Delegation Oversight Activities

SHP may delegate call center, claims, credentialing, case management, disease management, pharmacy benefit administration, and utilization management activities to entities and provider groups that meet delegation requirements. SHP conducts delegation assessments to determine compliance with regulatory and accrediting requirements. The health plan monitors ongoing compliance with review of policies and procedures, monthly reports, and annual assessments.

SHP maintains a Delegation Oversight Committee, a sub-committee of the Compliance Council, that meets monthly to review pre-delegation and ongoing monitoring activities.[viii]

Dental Plan Partners

IHN-CCO ensures members have access to comprehensive dental services and oral health care by delegating this benefit to dental plan partners. IHN-CCO delegates the dental benefit and administration of the benefit to four (4) contracted dental plan companies as a delegated entity. The four dental partners include Advantage Dental, Capitol Dental Care, ODS, and Willamette Dental Group. The Dental Plans subcontract with dental providers to provide comprehensive and ongoing assessments of dental needs, medical needs related to dental care, and develop treatment plans. IHN-CCO ensures member care is comprehensive and coordinated through the interdisciplinary care team (ICT) process.

Dental plans also ensure members are provided oral health covered services within the scope of the member's benefit package of dental coverage. This is done through an auto-adjudication process with claims to ensure equitable and appropriate treatment of membership related to access to benefits. In addition, members may request coverage of non-covered dental treatment and it will receive a multi-layer review of multiple qualified dentists prior to a decision of extra coverage.

Dental plans maintain a Quality Assurance and Quality Improvement Program in addition to the IHN-CCO executed Oversight audit to ensure compliance with regulatory guidelines and contractual obligations. Elements of oversight include:

- Clinical Practice Guidelines (bi-annually)
- Grievance Analysis (annually)
- Delivery System Network Monitoring (quarterly)
- Provider Directory review (quarterly)
- Workflow of provider directory maintenance
- Timely Access Monitoring (monthly)
- Dental Access review based on member urgency (annually)
- Ease of referrals for long term specialty care (annually)
- Prior Authorization review and Inter-Rater Reliability process review (annually)
- Chart review for Special Health Care Needs membership (annually)
- Business Continuity & Disaster Recovery (annually)
- Benefit adjudication process (annually)
- Utilization Management (annually)
- Electronic Health Record provider education and tracking (annually)
- Health Information and Data Integration (annually)
- OIG (Office of the Inspector General) exclusion review (annually)
- Encounter Validation (quarterly)
- Miscellaneous policy and workflow review after implementation of a new process (ex. Transition of care) (ad hoc)

In addition, IHN-CCO leads the effort to integrate a caries risk assessment internal to the hospital system. Referrals are then generated on an individual basis determined by the level of risk a patient has related to developing cavities. Dental Partners and SHP are working together to develop a referral pathway through the Unite Us platform.

IHN-CCO has internal staff chairing the Regional Oral Health Coalition. This ensures that regional level efforts are tied directly to IHN-CCO members and their needs.[ix]

Long Term Services and Supports

IHN-CCO maintains a care coordination agreement with Oregon Cascades West Council of Governments (OCWCOG) Senior and Disability Services (SDS) for members who require Long-Term Services and Supports (LTSS). To improve person-centered care, SHP maintains a memorandum of understanding (MOU) with both Oregon Cascades West Council and Senior and Disability Services (SDS). This MOU includes:

- Individualized care teams (ICT)
- Transitional care practices
- Member engagement

The purpose of the agreement is to clarify roles and responsibilities of each entity to ensure coordination between the two systems to provide quality care, and to produce the best health and functional outcomes for individuals to prevent escalation or duplication of services. The objective is to improve person-centered care, align care and service delivery and provide the right care at the right time in the right place for members who require LTSS.[x]

Non-Emergent Medical Transport

IHN-CCO ensures members have access to safe, reliable, timely and appropriate Non-Emergent Medical Transportation (NEMT) to and from covered appointments. NEMT services are contracted as participating providers and have been delegated to Oregon Cascade West Council of Governments through their Ride Line Program. NEMT services are accessed through a toll-free call center and available to members twenty-four (24) hours a day, three hundred and sixty-five (365) days per year. The NEMT services are covered at no cost to the member. NEMT transportation providers must comply with local, state, and federal safety standards and ensure appropriate qualifications and training for drivers.

IHN-CCO conducts an annual oversight audit for this delegated partner to ensure quality assurance of these benefits and services. The following elements are reviewed:

- Approved Rides universe (annually)
- Encounter Validation (quarterly)
- Denied Rides universe (annually)
- Quarterly NEMT Report (quarterly – OHA template)
- Driver level review (annually)
- Vehicle level review (annually)
- Grievance analysis (annually)
- Call Center review (annually & quarterly)
- Policy & Procedure review (Bi-annually)
- Business Continuity & Disaster Recovery (annually)
- Accidents and incidents (ad hoc and annually)

In addition, Ride Line hosts a Transportation Brokerage Advisory Committee that IHN-CCO staff chairs. During these meetings we discuss operational improvements, provider trending barriers to provide safe and appropriate care to members, as well as member level grievance trends.[xi]

Special Needs Plan Model of Care

The Special Needs Plan Model of Care (MOC) provides a framework for quality improvement and methods to ensure the unique needs of members enrolled in our Special Needs Plan are identified and addressed. The Centers

for Medicare and Medicaid Services (CMS) sets guidelines for Medicare Advantage plans' MOC and requires approval by the National Committee for Quality Assurance (NCQA). SHP is also required to have a contract with the Oregon Health Authority (OHA) to operate a Medicare Advantage Dual Special Needs Plan (D-SNP) for members dually eligible for Medicare and Medicaid. The goal is to ensure coordination of care and payment to effectively support the special health care needs of this vulnerable population.[xii]

Patient Safety

Patient safety is a health priority and health care discipline that has emerged in response to the rise of patient harm in health care facilities. Marked by an emphasis on continuous improvement, patient safety is focused on preventing errors and harm and reducing risks associated with the provision of care. Safe and high-quality care are fundamental to achieving the Quadruple Aim of Healthcare (optimizing health and wellbeing with a focus on safety, increasing affordability, engaging care teams and partners, and enhancing the care experience). Through our Member Safety Program, SHP aims to create a more collaborative and secure healthcare system for our communities. Toward this objective, SHP is promoting High Reliability Organization (HRO) methodology as an essential component in improving patient safety and quality of care.

High Reliability Organization

The foundation of safety is high reliability and Zero Harm is our overarching goal. SHS has engaged Press Ganey to implement Healthcare Performance Improvement (HPI) training and methodologies to transform our organization into an HRO (High Reliability Organization). There are five high-reliability principles that enable HROs to achieve and maintain safety.

- **Sensitivity to operations** – large threats typically appear as slight changes in the organization's operations and reporting any deviation from expected performance
- **Reluctance to simplify** – acceptance that healthcare is complex with potential to fail in new and unexpected ways
- **Preoccupation with failure** – never satisfied
- **Deference to expertise** – HROs have mechanisms in place to identify the individuals with the greatest expertise relevant to managing the new situation or place decision-making authority with the individual or group with the greatest expertise
- **Commitment to resilience** – despite best efforts and past success, errors will occur, but those errors do not disable the system by becoming larger problems

Adopting a Zero Harm goal is commitment to developing a new high-reliability culture in which our improvement efforts are focused squarely on eliminating harm, injury, and failure.

Safety Culture

The overarching goal of our patient safety program is to create a culture of safety and high reliability within the care delivery system. The Agency for Healthcare Research and Quality (AHRQ) defines the safety culture of an organization as the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, and organization's health and safety management. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. In creating a culture of safety, we are concerned with provider and care team burnout and multiple dimensions of safety.

With a focus on safety culture, we are convening stakeholders to apply high-reliability science to healthcare and develop strategies to improve care coordination and member experience across the continuum of care.

MEMBER SAFETY INITIATIVES

- **Analyzing adverse-event reporting** to identify systems issues that contribute to poor safety
- **Evaluating clinical practice** against evidence-based practice guidelines that improve safety
- **Implementing pharmaceutical management practices** that require safeguards to enhance patient safety
- **Improving continuity and coordination** of care between practitioners to avoid miscommunication that can lead to poor outcomes

Safety initiatives are identified through a set of indicators providing information on harm, injury, or failure. The indicators also include occurrences that are unusual or may indicate a concern in quality of care or services in either an inpatient, outpatient, or community setting. Indicators are screened, investigated, trended, and monitored by the QI department. Indicators developed are followed by an in-depth assessment. Outcomes are aggregated and reported at least annually.

The following oversight initiatives help assure SHP members receive safe, high-quality on a continuous basis. Health care safety is assessed using readily available administrative data i.e., survey and claims, grievance data, and medical record data.

Preventable/Never Events

Preventable/Never Events include both Hospital-Acquired Conditions and Serious Reportable Events as defined by CMS. Hospital-acquired conditions originate in any inpatient hospital setting and are identified as: (a) excessive cost or high volume or both, (b) result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis, and (c) could have been prevented through the application of evidence-based guidelines. Serious reportable events are an error in medical care which are clearly identifiable, preventable, serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility.

Preventable/never events are grouped into seven categories:

- Care management events
- Criminal events
- Environmental events
- Patient protection events
- Product or device events
- Radiological events
- Surgical or procedural events

Preventable and Never Events are evaluated according to SHP policy.[xiii]

Quality of Care Concerns

SHP has established reports to identify potential quality of care concerns. Cases may also be referred from providers or identified through health plan processes such as claims, utilization review, complaints, and grievances.

Examples may include:

- Treatment in an Emergency Department (ED) within seven days of discharge of an inpatient facility for the same diagnosis
- Readmission to the hospital within seven days of discharge
- Post-surgical infections
- ED treatment or inpatient admission for hypertensive crisis/malignant hypertension
- Any other occurrence that would impede care or access to care
- Inappropriate Level of Care (LOC) determinations
- Member safety such as abuse, neglect, or exploitation

Clinical reviewers evaluate trends and individual cases for quality-of-care concerns. When a quality-of-care concern is confirmed, a corrective action plan is developed and implemented with stakeholders. SHP may also refer cases to the Credentialing committee for peer review.

Drug Utilization Review

The standard prospective and concurrent drug utilization review (DUR) programs are delegated to the designated pharmacy benefit manager (PBM), Optum, utilizing the standards, criteria, protocols, and procedures established by agreement of the SHP Pharmacy department and Optum, in accordance with applicable state and federal requirements and NCQA standards. The DUR program also functions to identify opportunities to improve the quality of care for members by evaluating patient adherence to prescribed therapy and improvements in the medication regimen as appropriate for the patient's diagnoses or conditions. The results of retrospective review may also be used to initiate additional claims review and analysis. Follow-up studies may be performed to assess the impact and outcomes of DUR program interventions. The SHP Pharmacy department uses information identified through the DUR program to develop education and outreach to pharmacies, prescribers, and members. The DUR program is submitted for review and approval to the P&T annually.[xiv]

Medication Therapy Management

The Medication Therapy Management (MTM) program offers a comprehensive approach to improve medication use and reduce the risk of adverse events and improve medication adherence. The program follows Medicare Part D requirements and the expansion of MTM to Medicaid and high-risk commercial members. The MTM program aims to identify an additional group of at-risk Medicare beneficiaries beyond the CMS minimum requirements, taking a multidisciplinary approach to MTM, coordinating engagement with beneficiaries with outreach and interventions by case management as appropriate. Pharmacists working under SHP's MTM vendor collaborate with our primary care providers to promote MTM services to our members. The goal of the MTM program is to improve the safety and effectiveness of pharmacotherapy for members, leading to improved medical outcomes and efficiencies. Improvement will be achieved through pharmacist or pharmacist-directed interventions with members, physicians, or provider pharmacies regarding the pharmacy co-therapeutic management of chronic conditions. A comprehensive medication review is offered at least annually to all targeted members enrolled in the plan's MTM program.[xv]

Utilization Management

Utilization management (UM) is integrated within the Care Coordination care management program. The Chief Medical Officer and the Medical Director-Care Coordination oversee the program operations. Utilization review is conducted according to department policies, procedures, and clinical criteria. Medical necessity is determined, and the decision period and notifications must adhere to policies and plan documents. Prospective, concurrent, and retrospective reviews are performed to provide a basis for decision-making. UM decisions are made by qualified,

licensed healthcare professionals who have the knowledge and skills to assess clinical information and to evaluate working diagnoses and proposed treatment plans. Care Coordination is supported by board certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed physicians oversee UM decisions to ensure consistent and appropriate medical-necessity determinations. Inter-rater reliability (IRR) reviews are conducted to ensure consistent application of the utilization criteria.

Monitoring for over-utilization and under-utilization occurs through utilization and case management reports. Additional monitoring comes from clinical performance measures, including HEDIS which captures race, age, sex, and socioeconomic status (income, disability, and combinations). Along with these sources, new reports are in development that will aggregate household language and apply it to other reports to approximate a linguistic and ethnic view into utilization patterns. This may indicate inequitable needs to be addressed in the resultant sub-populations. All sources of member satisfaction surveys, complaints, appeals, and grievances are reviewed to identify potential areas of concern. Practitioner medical, pharmacy and utilization profiles are also reviewed.[xvi]

Transitions of Care

The SHP care management team ensures member care is coordinated and continuous for members who are experiencing a transition of care from one setting to another or between health care practitioners or episode of care through established care management processes. SHP care managers convene and participate in interdisciplinary care team meetings and develop individualized care plans which are shared with the member. This ensures care plans are adapted to members' needs and understood by all using the teach back method. SHP care managers coordinate with providers and community agency partners to manage care between settings including hospitals, and Oregon State Hospital (OSH), acute care nursing and rehabilitative facilities, hospice, home health and home. Care coordination practices integrate cross-system education, timely information sharing, and coordination to avoid duplication of effort and to ensure effective deployment of interdisciplinary nursing and psycho-social resources.

IHN-CCO provides seamless continuity of care and services during a member's transition between CCO's or fee-for-service Medicaid. IHN-CCO provides care coordination to ensure members have continued access to care for members identified as prioritized or who have special needs. Whether members are newly enrolled in IHN-CCO or transferring to another CCO, IHN-CCO works collaboratively with other CCO's providers, and social agencies to ensure a successful transition. Member centered elements of transition of care activities are monitored to verify regulatory compliance and identify any areas of concern where corrective action may be needed.[xvii]

Quality and Service Improvement

SHP Quality and Service Improvement initiatives are identified through QI Program activities. QI projects are selected and designed to achieve Quadruple Aim goals and leverage QI tools and resources to achieve the best outcomes to benefit the member population. SHP fosters a robust QI Program focused on transforming the delivery system and driving value-based care.

Quality Improvement Projects

Quality Improvement (QI) methodologies such as Lean Six Sigma, Root Cause Analysis, and Plan, Do, Study, Act (PDSA) cycle are used to improve processes. QI process methodologies are structured to identify and analyze significant opportunities for improvement in care and service. The development of improvement strategies and systematic tracking determine whether these strategies result in progress toward established benchmarks or goals.

Focused QI activities are carried out on an ongoing basis to promote efforts to identify and correct quality of care issues.[xviii]

Chronic Care Improvement Program

The Chronic Care Improvement Program (CCIP) for Medicare Advantage members ensures members with chronic conditions are effectively managed. Our SAHP CCIP focuses on the implementation of a Hypertension Control Program for members identified as having a diagnosis of Hypertension. Our SNP CCIP focuses on improving the treatment engagement rate for members identified with a substance use disorder.[xix]

Each CCIP is made up of two components:

- **The Plan Section** describes the criteria for the CCIP, including the methodology used for identifying participants, mechanisms for monitoring participants, and performance assessments.[xx]
- **The Annual Update** describes the Medicare Advantage Organization's progress in implementing the CCIP, including systematic and ongoing follow-up.[xxi] The MAO must also report status and updates to CMS as requested.[xxii]

IHN-CCO Performance Improvement Projects

SHP conducts Performance Improvement Projects (PIPs) to examine and improve care and health outcomes in areas identified for improvement. This is in accordance with the OHA 1115 demonstration waiver, the CCO Contract and federal requirements.[xxiii] SHP has four PIPs, including a statewide PIP for which all CCO's in Oregon are required to address the same topic or problem. Topics and interventions for the remaining three PIPs are determined by SHP, relevant to IHN-CCO's unique population and member needs. PIPs are regularly reported to OHA. In support of our PHM strategy, SHP's four PIPs include:

- Addressing high-risk pregnancies to reduce pre-term births
- Improving comprehensive care for members with diabetes and co-occurring substance use disorder (SUD)/serious mental illness (SMI)
- Increasing adolescent well-care visits for members ages 12-21
- Mental health service access monitoring (Statewide PIP)

PIPs typically run for three years and are subject to change based on the current Quality and PHM strategy and feedback from OHA. IHN-CCO reports PIP progress to OHA on a quarterly basis.

Transformation and Quality Strategy

The Transformation and Quality Strategy (TQS) is an OHA initiative required for CCOs. The objective is to move health transformation forward to meet the triple aim of better health, better care, and lower costs. In 2018 OHA replaced the CCO Transformation Plan with the TQS. The programs and projects included within the TQS aim to make significant movement in health system transformation and to coordinate internal CCO transformation and quality initiatives. IHN-CCO conducts an annual evaluation of progress toward goals for each section of the TQS. This evaluation informs the updates to the TQS program, which are made during October through January under the guidance of the TQS Taskforce.

The TQS is comprised of three sections:[xxiv]

- **Section 1: Transformation and Quality Project Details** is a comprehensive overview of initiatives that IHN-CCO undertakes to meet OHA's 16 prioritized components.

- Access Quality and Adequacy of Services - assessment and analysis of the quality and effectiveness of monitoring, evaluating, and improving access, quality, and appropriateness of services to ensure that all covered services are available and accessible to IHN-CCO members, including how transportation is provided.
- Access: Cultural Considerations - assessment and analysis of the quality and effectiveness of monitoring, evaluating, and improving the access, quality and appropriateness of services provided to members consistent with their cultural and linguistic needs.
- Access: Timely - assessment and analysis of the quality and effectiveness of monitoring, evaluating, and improving timely access to services provided to members. Timely access projects must address both 1) travel time and distance, and 2) timely appointments.
- Behavioral Health Integration - development and implementation of an equitable, integrated, person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral, and oral health and supports all integration models from communication to coordination to co-management to co-location to the fully integrated patient-centered primary care home and behavioral health home.
- CLAS (Culturally and Linguistically Appropriate Services) Standards - implementing activities to support the National Culturally and Linguistically Appropriate Services (CLAS) standards. The National CLAS standards establish a blueprint (CLAS Standards Blueprint) and provides specific recommendations for addressing inequities at every point where the member has contact with the health care system.
- Grievance and Appeal System - assessment and analysis of the quality of the grievance and appeal system (inclusive of complaints, notice of actions, appeals and hearings), including aggregate data to indicate IHN-CCO's quality improvement activities.
- Health Equity: Data - adopt processes that allow stratification of quality data by patient race, ethnicity, and language in every area of the organization as a tool for providing culturally and linguistically appropriate services to advance health equity and for uncovering and responding to health care disparities.
- Health Equity: Cultural Responsiveness – IHN-CCO ensures members receive effective, understandable, and respectful care from all CCO staff and the provider network. IHN-CCO ensures that health and health care services (including physical health, behavioral health, substance use disorder and oral health services) are provided in a manner compatible with members' cultural health beliefs, practices, preferred language, and communication needs.
- Oral Health Integration - development and implementation of an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral, and oral health.
- PCPCH: Member Enrollment – IHN-CCO ensures that a significant percentage of members are enrolled in PCPCHs recognized as Tier 1 or higher according to Oregon's PCPCH recognition standards.
- PCPCH: Tier Advancement - a comprehensive plan to support PCPCH practices in upward tier recognition that include targets and benchmarks supporting PCPCHs to advance from Tier 1 toward Tier 5 (5 STAR) in Oregon's PCPCH recognition standards.
- Serious and Persistent Mental Illness (SPMI) - demonstrate improvement in an area of poor performance in care coordination for members with SPMI, even if this population overlaps with other designations such as civil commitment, aid and assist, and the psychiatric security review board.

  - Social Determinants of Health and Equity (SDOH-E) - development and implementation of initiatives to address the community-level social, economic, and environmental conditions that impact health, or the social determinants of health (SDOH).
  - Special Health Care Needs (SHCN): Full Benefit Dual Eligible Population - identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how IHN-CCO expects members with special health care needs will benefit and see improvement from the project.
  - SHCN: Non-Duals Medicaid Population - identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how IHN-CCO expects members with special health care needs will benefit and see improvement from the project.
  - Utilization Review - reviewing, evaluating, and ensuring appropriate use of medical resources and services encompassing quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services
- **Section 2: Discontinued Project(s) Closeout** informs OHA of any previous TQS initiatives that are no longer being pursued by IHN-CCO, what the outcomes of the projects are, and the reason(s) that IHN-CCO is discontinuing the projects.
- **Section 3: Required Quality Program Attachments** informs OHA how IHN-CCO meets the Quality management and structure following state regulatory requirements:

The development and management of IHN-CCO's TQS program is overseen by the TQS Taskforce, who then reports progress and findings up to the Quality Improvement Committee (QIC). The QIC reviews and approves TQS Documentation, as developed by the Taskforce, prior to the TQS submission to the Oregon Health Authority for scoring and feedback.

IHN-CCO's 2021 TQS efforts include:

TQS Program	Aligned Component
Building a Trauma-Informed Community	Social Determinants of Health & Equity
Correlation between utilization of Psychiatric Residential Treatment Services (PRTS) for youth and availability of Intensive Outpatient Services and Supports (IOSS)	Utilization Review, Access: Quality and Adequacy of Services
Gender Identity and Pronouns	Health Equity: Cultural Responsiveness, Health Equity: Data
Grade A CLAS	Access: Cultural Considerations, CLAS Standards: Health Equity: Cultural Responsiveness
Patient-Centered Primary Care Home (PCPCH) Member Enrollment	PCPCH: Member Enrollment
PCPCH Value Based Payment Model	PCPCH: Tier Advancement
Timely Hospital Follow Up for FBDE Members	Special Health Care Needs (SHCN), Access: Timely, Utilization Review
Warm Handoffs	Behavioral Health Integration, Serious, and Persistent Mental Illness (SPMI)
Wellness to Smiles	Oral Health Integration

Service Improvement Projects

Appeals and Grievances

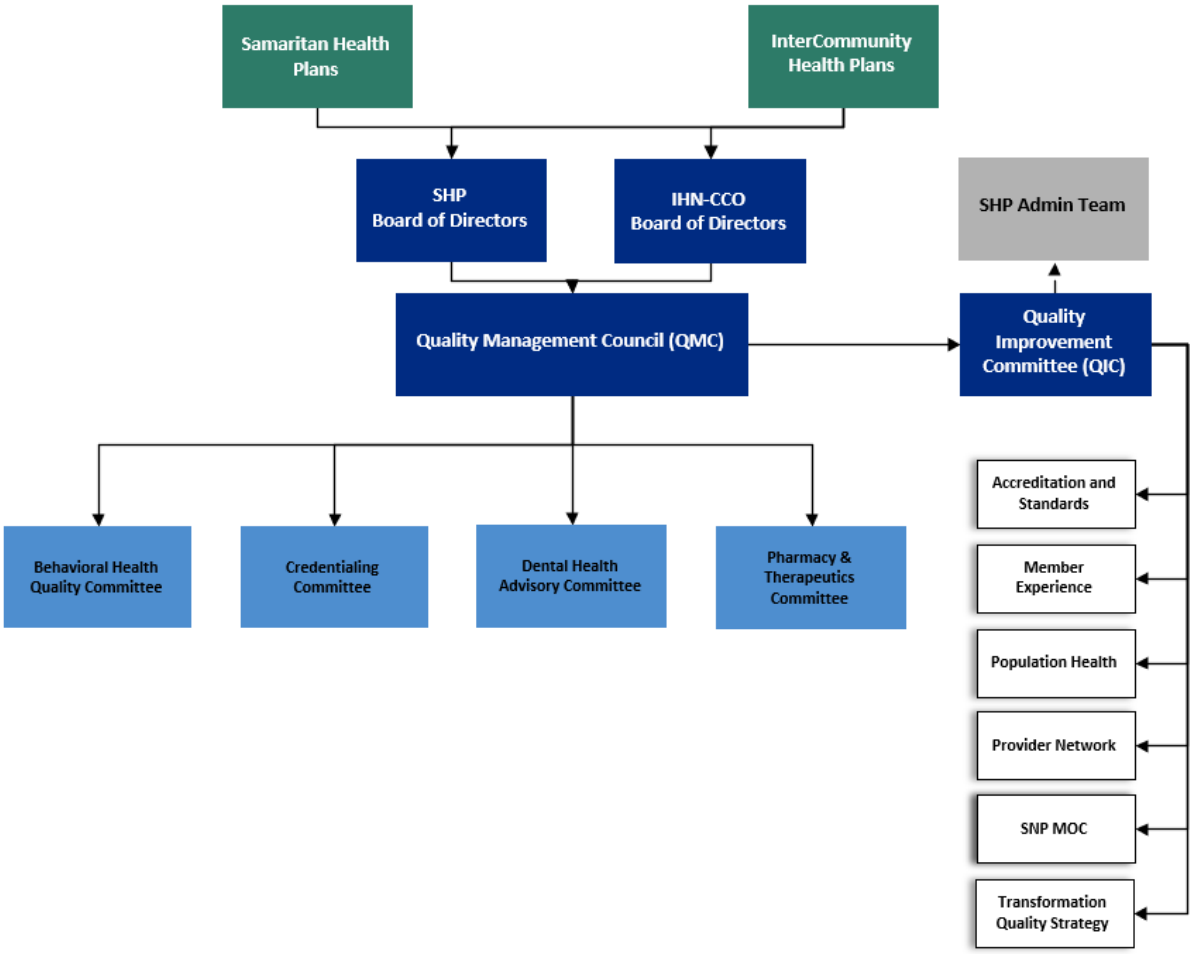
SHP continuously evaluates complaints, appeals and grievances to determine trends and improvement initiatives. Multi-disciplinary teams are engaged to address identified areas for process improvement. In 2021 the SHP Strategy Division implemented a workgroup solely dedicated to reviewing and analyzing complaints and grievances specific to IHN-CCO. The QIC reviews, analyzes, and monitors complaints, appeals and grievances quarterly.[xxv]

Quality Governance and Systems

The Quality Governance and Systems section includes committee structures, roles and responsibilities, quality information systems and quality data reporting, Health Equity, Delegation and Oversight, Program Audits, the QI Workplan and confidentiality and security of information.

Committee Structure: Roles and Responsibilities

Samaritan Health Plans Board of Directors, as governing body, maintains overall accountability of the QI Program.



Board of Directors

Samaritan Health Plans' Board of Directors (BOD) oversees all Advantage and Commercial health plans. IHN-CCO BOD oversees InterCommunity Health Network. These governing bodies maintain overall accountability and responsibility of the QI Program. The BOD communicates any recommendations to the Chief Medical Officer.

Quality Management Council

The SHP boards have designated the Quality Management Council (QMC) as the entity responsible for the oversight and management of all quality-related activities. The QMC serves as the clinical advisory panel (CAP) for IHN-CCO. The QMC is chaired by the Chief Medical Officer and is comprised of community partners and network clinicians representing primary care, behavioral health, oral health, and specialties. SHP functional area directors and health plan staff participate as required. QMC meets at least quarterly.[xxvi]

RESPONSIBILITIES OF THE QMC INCLUDE:

- Coordinate and disseminate best practices and policies, clinical practice guidelines (CPG's), and UM guidelines
- Review and approve the annual QI Program and Program Evaluation, Care Coordination Plan, and Special Needs Plan Model of Care (SNP MOC) Annual Evaluation
- Review and evaluate utilization data to identify gaps in service delivery
- Review, approve, analyze, and evaluate results, make recommendations and policy decisions, institute needed actions and ensure appropriate follow-up regarding quality activities, including but not limited to CCO metrics, Stars, HEDIS, CAHPS (Consumer Assessment of Healthcare Providers and Systems), and HOS measures and clinical and service quality initiatives
- Serve as Utilization Review oversight committee to provide oversight of utilization against Utilization Management (UM) guidelines and Clinical Practice Guidelines (CPGs
- Set direction and oversee Quality Improvement (QI) activities and sharing between entities of Linn, Benton and Lincoln Counties Set goals to improve health outcomes and identify high-risk barriers for appropriate access to care
- Understand and provide oversight of SHP quality and performance indicators i.e., Stars, HEDIS (Healthcare Effectiveness Data and Information Set), HOS measures, and IHN-CCO metric requirements

Quality Improvement Committee

The Quality Improvement Committee (QIC) is chaired by the Chief Medical Officer. QIC includes cross-functional areas, leadership, and staff. The committee is responsible for leading and overseeing the quality and service improvement activities for the organization. The goals of this committee are focused on improving member health outcomes, improving member and clinician experience, and reducing health care costs. QIC activities are to monitor, evaluate and analyze data to identify gaps and develop interventions as indicated on our annual QI Workplan.[xxvii]

RESPONSIBILITIES OF THE QIC INCLUDE:

- Design and maintain the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement.
- Meet Regulatory requirements for Quality Improvement as described in 42 CFR 422.152, 42 CFR 423.153, OAR 410-141-3525
- Support clinicians with participation in quality improvement initiatives of SHP and all governing regulatory agencies.

- Analyzes and evaluates the results of Quality Improvement (QI) activities and reporting. Including: CCO Metrics, CAHPS, CMS Stars, HEDIS, HOS and quality measures used for Value Based Payment program (VBP).
- Establish clinical and service indicators that reflect the demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and or periodic monitoring and evaluation.
- Measure the availability and accessibility to clinical care and services.
- Measure member satisfaction to identify and address areas of dissatisfaction in a timely manner through quarterly analysis of trended member appeals and grievance/compliant data, member satisfaction surveys, and member suggestions to improve care and services and ensure organizational compliance with member rights and responsibilities policies and procedures.
- Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improved performance and/or validate a problem or measure conformance to standards.
- Oversee delegated activities by establishing standards, monitoring performance, and evaluating performance annually.
- Monitor over and underutilization of services
- Oversight of QIC taskforces and workgroups
- Implement and maintain health promotion activities and disease management programs linked to QI actions to improve performance. These activities include identification of high-risk and/or chronically ill members, education of clinicians, and outreach programs to members.
- Create and maintain infrastructure to achieve accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting bodies as appropriate.
- Oversee and approve the Transformation and Quality Strategy (TQS) plan to align transformation and quality work
- The QIC recommends and revises, or oversees recommendations and revisions to, policies for effective operation of the QI Program and achievement of QI Program objectives.

TASKFORCES

- **Accreditation and Standards:** Guide the organization in implementing industry best practice that aligns with the National Committee for Quality Assurance (NCQA) accreditation standards.[xxviii]
- **Member Experience:** Assess data, develop solutions, and implement interventions to improve member communications and overall experience; and identify opportunities for benefit optimization. Acting as the voice of the member to the QIC, the taskforce is vital to driving the organization's pursuit of quality and service excellence.[xxix]
- **Provider Network:** Driving change in the provider network by addressing network adequacy and member needs. This Taskforce will place a focused effort on alleviating the burden of administrative tasks placed on the providers, improving provider satisfaction, and further developing and improving network relationships.[xxx]
- **Special Needs Model of Care (SNP MOC):** Guides the organization in the development, coordination, and implementation of the SNP MOC program, continually informing and collaborating with the Quality Improvement Committee (QIC). This collaboration of cross-departmental efforts will ensure our most vulnerable members have the best possible coordination of care and health outcomes.[xxxi]
- **Population Health:** Guide the organization on metric and measure status. Prioritize, develop, and implement plans focused on improving measure outcomes and achieving organizational goals.[xxxii]

- **Transformation and Quality Strategy:** Oversight, monitoring, and execution of the IHN-CCO Transformation and Quality Strategy (TQS) program and subsequent projects to ensure alignment with organization priorities and transformation strategy as required through the OHA CCO 2.0 Healthcare Services Contract.[xxxiii]

Behavioral Health Quality Committee

The Behavioral Health Quality Committee (BHQC) includes behavioral health providers, community partners and health plan leadership and staff. The committee meets quarterly. BHQC oversees planning for and evaluation of the behavioral health needs of members, the behavioral health delivery system, capacity, and treatment programs for substance use disorder, and mental health. The BHQC evaluates care coordination, integration with larger care delivery system, and the utilization and quality outcomes of behavioral health services provided to members. BHQC promotes coordination of care and resources with community partners and jurisdictional stakeholders.[xxxiv]

Credentialing Committee

Samaritan Health Services (SHS) credentialing committee is comprised of the SHP Chief Medical Officer, participating physicians, other health care professionals, and health plan staff as required. The committee meets monthly, face-to-face or via phone conferences. The credentialing committee reviews, denies, or terminates participation of physicians, clinicians, adjunct, and organizational providers. The credentialing committee is responsible for assuring network providers meet SHS's requirements for initial credentialing and recredentialing. The committee is responsible for developing the credentialing criteria, quality review and ensures all physicians and providers' qualifications meet the criteria. The credentialing services policies and procedures are reviewed at least annually.[xxxv]

Dental Health Advisory Committee

The Dental Health Advisory Committee (DHAC) is chaired by a dentist elected from the dental partner community. The DHAC provides oversight and monitoring of dental plan activities. The DHAC evaluates the integration of IHN-CCO members' dental health services with physical and mental health services in Linn, Benton, and Lincoln counties, to advance the improvement of member experience and health outcomes. The DHAC maintains an understanding of dental health metric requirements, identifies elevated risk barriers for access, evaluates utilization data to identify gaps in service, and creates strategies to ensure an achievable dental health outcome. The committee disseminates best practices and ensures collaboration and sharing between entities of Linn, Benton, and Lincoln counties. DHAC's membership is comprised of contracted ad hoc subject matter experts, IHN-CCO staff, and DCO (Dental Care Organization) staff. DHAC will resume meeting quarterly beginning in 2022.[xxxvi]

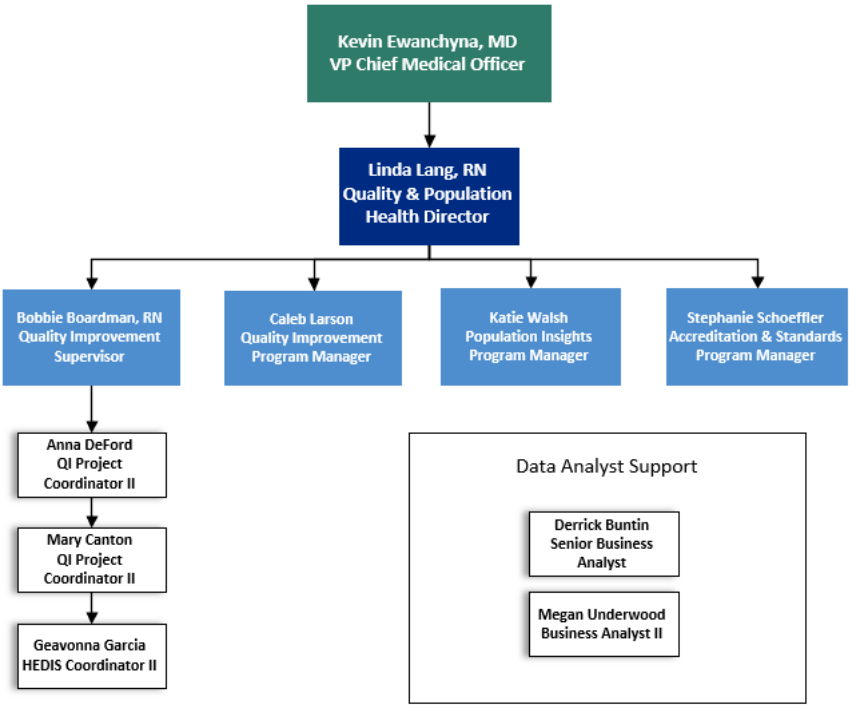
Pharmacy and Therapeutics Committee

The role and function of the Pharmacy and Therapeutics (P&T) committee is to ensure that the most clinically appropriate and cost-effective drugs will be available for members. The committee recommends the adoption of policies regarding evaluation, selection, and therapeutic use of drugs; recommends or assists in the formulation of programs to meet the pharmaceutical needs of practitioners and recommends and maintains the plan's formularies in accordance with pharmacy policies and procedures.

The P&T committee is composed of network physicians, pharmacists, and other health care professionals and staff who represent a cross-section of primary care and specialties. Membership includes at least one practicing physician and one practicing pharmacist who are experts in the care of the elderly or disabled persons. At least one

practicing physician and pharmacist will be free of conflicts of interest with respect to SHP. The P&T committee meets at least quarterly to review and vote on SHP Drug Review Board's formulary recommendations.[xxxvii]

Quality Personnel and Organizational Chart



Quality and Information Systems

Healthcare Effectiveness Data and Information Set

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. It is one of the most widely used sets of health care performance measures in the United States, which allows SHP to benchmark and compare performance with similar health plans across the nation.

HEDIS measures focus on:

- Prevention, screenings, and medication use
- Care provided for numerous conditions across all body systems
- Member's access to various health care services
- Overuse or receipt of inappropriate care
- Health care utilization for services and procedures in different care settings

HEDIS reporting is required for SHP's SAHP and SNP lines of business. Measures are calculated by NCQA certified software using data from claims, supplemental data collected from electronic health records, and/or manual chart review. Reported HEDIS results are also audited annually by certified auditors using a rigorous process designed by NCQA including an onsite visit focused on information and reporting systems. HEDIS measure results are a key component in the Medicare Star Ratings and are used to target specific opportunities for improvement.[xxxviii]

Oregon Health Authority CCO Metrics

OHA uses outcome and quality measures to demonstrate performance among Coordinated Care Organizations (CCOs) to improve the quality of care, eliminate health disparities and reduce costs. Measures fall into one of two categories: CCO Incentive measures, for which CCO's are eligible to receive payments based on their performance each year; and State Quality measures, which OHA has agreed to report to CMS as part of Oregon's 1115 Medicaid waiver. IHN-CCO maintains a dashboard of performance metrics to evaluate performance and engages network providers in quality improvement initiatives to improve performance.

Medicare Stars Program

The Medicare Part C & D Star Ratings were developed by CMS to help beneficiaries compare health plans and providers based on quality and performance and to reward top-performing health plans. Star ratings include quality measures designed to evaluate success in providing preventive services, managing chronic illness, access to care, HEDIS measures, the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey and responsiveness. Both medical (Part C) and pharmacy (Part D) measures are included in the star rating. Health plans are assigned a star rate for each measure (one through five with five being the highest) as well as an overall summary star rating.

SHP's goal for SAHP is to continue to improve performance across SHP and the provider network and advance to 5 Star rating. Select star measures are included each year in provider value-based payments.[xxxix]

Consumer Assessment of Healthcare Providers and Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey is a tool for collecting standardized information on members' experiences that cannot be assessed by other means.

The CAHPS survey gives members the chance to review SHP and their providers as well as rate the quality of care they have received and includes questions from the following domains:

- Your Healthcare in the Last 6 Months
- Your Personal Doctor
- Getting Healthcare from Specialists
- Your Health Plan
- Your Prescription Drug Plan
- About You

The survey is conducted every year and SHP uses the survey results to identify opportunities to improve the overall member experience.

CAHPS survey results are analyzed and reported to the QMC and QIC annually.

CAHPS IHN-CCO (MEDICAID)

The CAHPS survey is conducted in the spring of each year (for the previous reporting year). A mixed mail and telephone survey administration methodology is used. OHA conducts this survey for the Medicaid adult and child populations on SHP's behalf.

CAHPS SAHP (MEDICARE)

Symphony Performance Health (SPH) Analytics, an NCQA certified survey vendor, conducts the annual CAHPS survey for our adult Medicare members. A mixed mail and telephone survey administration methodology is used. The results of this survey are a key part of the Medicare Stars rating.

Health Outcomes Survey

The Health Outcomes Survey (HOS) measures the physical and mental well-being of Medicare members over time. It is administered annually to a random sample of SAHP members who receive the survey again at the end of a 2-year period. The two survey results are compared to determine if the care received is keeping the member as healthy as possible.

The HOS is comprised of several components including questions:

- To evaluate the members' physical and mental health
- To address important problems associated with poor physical and mental functioning such as urinary incontinence, lack of physical activity, and fall risk
- Related to chronic conditions, activities of daily living, and sociodemographic information

HOS results from questions related to bladder control, physical activity, and fall risk are used in the health plans Medicare Star Rating.

Medicaid Efficiency and Performance Program

CCOs are required to participate in the OHA Medicaid Efficiency and Performance Program (MEPP), which is administered through the OHA Actuarial department to focus upstream on initiatives to improve quality and reduce the overall cost of care. The OHA Actuarial department introduced Prometheus Analytics, a tool provided by Optumas to analyze episodes of medical care and identify population risk and potentially avoidable costs in the CCO program. Prometheus Analytics uses encounter data to identify cost drivers and Potentially Avoidable Complications (PACs). Prometheus Analytics separates episode costs between “typical” and “PACs.” This tool allows IHN-CCO to review and summarize episode costs by multiple dimensions to impact quality improvement through the lens of efficiency and quality. This is in keeping with the SHP goal of achieving the triple aim by developing projects to improve quality and reduce costs by focusing on upstream factors that drive costly conditions and procedures. SHP has developed three initiatives for IHN-CCO to reduce costs and improve care. The three initiatives are designed for members with diabetes and co-occurring behavioral health conditions; pregnancy by reducing unnecessary cesarean deliveries; and hypertension with rising risk factors.

Key Performance Indicator Tracking

Quality improvement is a data driven process and used to monitor performance through established benchmarks and performance goals. To inform on the progress of quality improvement initiatives, and focus prioritization, SHP has defined a set of industry aligned outcome measures centered around 3 domains: preventive health, safe and effective care, and member experience. These measures serve as key performance indicators (KPIs) aligned with program initiatives, however, do not reflect all quality and performance measures monitored by SHP. See Appendix I for 2022 KPIs.

MEMBER EXPERIENCE

Getting Appointments and Care Quickly is a CAHPS measure used to assess members' ability to access care in their specific region. This measure gives SHP insight on their network adequacy. Interventions for this measure are

centered around the Provider Network Taskforce who is continually assessing the network and developing strategies to expand and improve contracting.

Rating of Health Plan is a CAHPS measure used to assess members' overall view of their health plan. This measure gives SHP insight into member perception of the health plans quality and administration. Interventions for this measure center around the Member Experience Taskforce who is continually reviewing member experience data and developing strategies to positively impact member perception of the health plans.

SAFE AND EFFECTIVE CARE

Prenatal and Postpartum Care assesses whether timely prenatal or postpartum visits occurred during pregnancy and after delivery. The measure is broken into two separate rates:

- **Rate 1** – Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.
- **Rate 2** – Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Early preventive care during pregnancy is associated with better outcomes for both the parent and baby. It can help reduce poor birth outcomes including spontaneous abortion, low birth weight and neonatal infection. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend at least one exam during the first trimester for prenatal care for all pregnancies and provider follow up within three weeks postpartum, followed by ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. Interventions include rigorous care management, VBP (Value Based Payment) contracting, member education, and provider outreach.

Plan All-Cause Readmissions assesses the rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. A “readmission” occurs when a patient is discharged from the hospital and then admitted back into the hospital within a brief period. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination.

Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management. SHP is currently developing pathways to track and trend readmission to provide feedback to the provider network, additionally SHP has VBP (Value Based Payment) contracting.

Initiation and Engagement with Alcohol & Other Drug Abuse or Dependence Treatment assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug (AOD) dependence who received the following:

- **Initiation of AOD Treatment**: The percentage of adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication-assisted treatment (MAT) within 14 days of diagnosis.
- **Engagement of AOD Treatment**: The percentage of adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.

In 2020, 40.3 million Americans over 12 years of age (about 14.5% of the population) were classified as having a substance use disorder within the past year. Treatment, including MAT, in conjunction with counseling or other

behavioral therapies, has been shown to reduce AOD-associated morbidity and mortality, improve health, productivity and social outcomes and reduce health care spending. Despite convincing evidence, less than 20% of individuals with substance use disorders receive treatment. Interventions include value-based contracting, and provider education and outreach.

PREVENTIVE HEALTH

Childhood Immunization Status (Combo 3) measures the percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis (HepB); one chicken pox (VXZ); and four pneumococcal conjugate (PCV) vaccines by their second birthday. Childhood immunizations are essential for disease prevention and are a critical aspect of preventable care for children. Vaccination coverage must be maintained to prevent a resurgence of vaccine-preventable diseases. Interventions include member incentives, VBP (Value Based Payment) contracting, member education, and provider outreach.

Breast Cancer Screening measures the percentage of female members ages 50 to 74 who had a mammogram to screen for breast cancer. Although screening cannot prevent breast cancer, mammograms are the best method to detect breast cancer early, when it is easier to treat. Interventions include developing provider champions, VBP (Value Based Payment) contracting and member education.

Colorectal Cancer Screening measures the percentage of members ages 50-75 who had appropriate screening for colon cancer. Colorectal cancer usually develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps, so they can be removed before turning into cancer. Screening tests can also find colorectal cancer early when treatment works best. Interventions include VBP (Value Based Payment) contracting, member education, and provider outreach.

Controlling High Blood Pressure measures the percentage of plan members with high blood pressure who were able to maintain healthy blood pressure. High blood pressure can cause significant downstream effects on members' health outcomes including stroke, kidney failure and heart failure. Interventions for this measure include VBP (Value Based Payment) contracting with SHP's provider network, provider outreach, supplying care-gap lists to providers, and member education.

Diabetes Care: HbA1c is an important indicator of long-term glycemic control with the ability to reflect the cumulative glycemic history of the preceding two to three months. HbA1c not only provides a reliable measure of chronic hyperglycemia but also correlates well with the risk of long-term diabetes complications. Poor HbA1c control is defined as the percentage of diabetic members ages 18-75 whose most recent HbA1c level is greater than 9%, or who were not tested during the measurement year. Reducing A1c blood level results by 1 percentage point (e.g., from 8.0 percent to 7.0 percent) helps reduce the risk of microvascular complications (eye, kidney, and nerve diseases) by as much as 40 percent. Interventions include VBP (Value Based Payment) contracting, member education, and provider outreach.

Well-Child Visits is the percentage of children ages 3-6 who had one or more well-child visits with a PCP (Primary Care Provider) during the measurement year. Benefits of children receiving a well-child visit include:

- **Prevention**. Pediatricians have an opportunity to educate parents on nutrition and safety for at home and at school, additionally, scheduled immunizations prevent potential illnesses.
- **Tracking growth and development**. Tracking children's development, milestones, social behaviors, and learning year after year.

- **Raising concerns**. Provides parents the chance to bring concerns to their child's pediatrician on topics such as: developmental, behavioral, sleep, eating or having a good relationship with other family members.
- **Team approach**. Regular visits create strong, trustworthy relationships among pediatricians, parents, and children. The American Academy of Pediatrics recommends well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental, and social health of a child

Interventions include developing provider champions, sharing best practices, VBP (Value Based Payment) contracting, member incentives and member education.

Value Based Payment Methods

Financial stability is key to the sustainability of any organization. It is important that SHP's provider network is compensated in a manner that enables them to drive innovation and a culture of patient centered care based on quality. SHP is promoting the shift from a fee-for-service system that reimburses only on volume, to a system that holds providers accountable for quality and health outcomes and allows innovation to cultivate transformation on the front lines of care delivery. In accordance with CMS, SHP recognizes the definition of value-based care as "paying for health care services in a manner that directly links performance on cost, quality, and the patient's experience of care."

Health Equity: Member Race, Language, and Culture

IHN-CCO is developing and implementing strategies for promoting health equity throughout the organization. This includes training for the Board of Directors, leadership, and staff (including staff that work with other lines of business). IHN-CCO will improve the quality of care for members by ensuring employees and members feel safe and are always treated with respect and dignity. IHN-CCO will hold its provider network to the same standards of safety and respect.[xl]

Quality Improvement Annual Workplan

The QI Workplan governs the program structure and activities for the period of one calendar year. The QI Workplan includes quality improvement initiatives, targets, measures, and metrics, activities, and methods of performance tracking throughout the year to advance quality goals and meet regulatory requirements for each line of business.

The QI Workplan is focused on delivering the QI Program goals.

- Quarterly project implementation plans, data management, and monitoring processes to achieve SHP quality and population health goals and meet regulatory requirements
- Identifies specific measurements for quality and population health program goals and objectives and compliance activities
- Includes key milestones, improvement targets and measurements (KPIs)

Quality Improvement Program Evaluation

At least annually, the Quality department will facilitate a formal evaluation of the QI Program. The program evaluation informs the development of the QI Workplan for the coming year.[xli] The evaluation includes:

- An evaluation of the results of each QI activity implemented during the year and identifies quantifiable improvements in care and service
- Evaluates resources, training, scope, and content of the program and practitioner participation
- Evaluates the overall effectiveness of the QI Program
- Identifies limitations and barriers and makes recommendations for the upcoming year, including the identification of activities that will carry over into next year
- Identifies opportunities to strengthen member safety activities
- Trended indicator report and brief analysis of changes in trends and improvement actions taken because of the trends

Confidentiality

The QI program follows all Samaritan Health System (SHS) and Samaritan Health Plans HIPAA (Health Insurance Portability and Accountability) policies related to procedures, access, safeguards, and security of protected health information (PHI). All SHP personnel and committee members receive privacy and confidentiality training. HIPAA policies are reviewed with all staff upon hire and annually. SHP is authorized by regulatory agencies and by members to obtain and review medical records, including member and practitioner identities. Authorization is subject to all state and federal laws and regulations including Title 42 Code of Federal Regulations. Use of PHI is outlined in the SHS HIPAA policy, and a privacy notice is distributed to all members.[xlii]

ANNUAL REVIEW AND REVISON OF THE QUALITY MANAGEMENT PROGRAM

The Quality Improvement Program is reviewed at least annually and updated more frequently as appropriate. The Quality Management Council is accountable for approving the Quality Improvement Program.

Kevin Ewanchyna, MD

Chief Medical Officer, Samaritan Health Plans

Date: January 5, 2022

Appendix I

Key Performance Indicators

Measure	Domain	Primary Population	National Average	2020 Rate	2022 Goal	Measure Steward	Current Interventions
Controlling High Blood Pressure	Chronic Conditions	Members 18-85	Medicaid: 55.9% Medicare: 63%	IHN: 58.6% SAHP: 63.75%	IHN: 72.2% SAHP: 70.12%	NCQA	SAHP CCIP; Pharm Medication Adherence Efforts; VBP
Diabetes Care: HbA1c Poor Control		Members 18-75	Medicaid: 45.36% Medicare: 27.4%	IHN: 29.9% SAHP: 17.61%	IHN: 33.3% SAHP: 15%	NCQA	IHN PIP; Pharm Medication Adherence Efforts; VBP
Postpartum Care	Preventative Service	Pregnant Members	Medicaid: 75.07%	IHN: 75.3%	IHN: 61.3%	NCQA OHA	Maternity Case Management (IHN PIP); VBP
Breast Cancer Screening		Members 50-74	Medicaid: 53.71% Medicare: 69.43% Commercial: 71.23%	IHN: 53.97% SAHP: 70.86% COMM: 63.33%	IHN: 55% SAHP: 80% COMM: 71.23%	NCQA	HEDIS Annual Mailings; Member Education; VBP
Colorectal Cancer Screening		Members 50-75	Medicaid: 57.3% Medicare: 69.77%	IHN: 55% SAHP: 71.04%	IHN: 58% SAHP: 80%	NCQA	HEDIS Annual Mailings; Member Education; VBP
Well-Child Visits		Members 3-6	Medicaid: 68.8%	IHN: 54.6%	IHN: 78%	OHA	Member Incentive Program; PIP; VBP
Plan All Cause Readmission		All Ages	Medicaid: 10.03% Medicare: 11.7% Commercial: 4.88%	IHN: 7.9% SAHP: 7.07% COMM: 6.06%	IHN: 7% SAHP: 7% COMM: 5%	NCQA	
Initiation and Engagement of Substance Use Disorder Treatment	Safe and Effective Care	Members 13 and older	Medicaid: 14.14% Medicare: 5.09% Commercial: 13.99%	IHN: 19.5% SAHP: 6.98% COMM: 15.52%	IHN: 38.8% SAHP: 7.94% COMM: 16%	NCQA	SNP CCIP; VBP

References

[i] CSD-QM-22 Population Assessment and Risk Stratification Policy
[ii] CSD-QM-12 Member Health Education Program Policy
[iii] CSD-QM-05 Clinical Practice Guidelines Policy
[iv] CSD-BH-54 IHN-CCO Behavioral Health Services Policy
[v] CSD-CC-CM-44 Care Management Policy
[vi] CSD-CC-CM-44 Care Management Policy
[vii] CSD-CC-CM-13 IHN-CCO Intensive Case Management and Intensive Care Coordination Policy
[viii] CP-26 Delegated Entity Oversight and Monitoring Policy
[ix] NSC-31 CCO Dental Benefit Administration Policy
[x] 2021-2022 Fully Signed Memorandum of Understanding
[xi] NSC-29 NEMT Benefit Administration Policy
[xii] 2021 Special Needs Plan Model of Care
[xiii] CSD-CC-UM-68 Preventable Readmission Identification and Review Process Policy
[xiv] CSD-RX-29 Drug Utilization Management and Outreach Policy and CSD-RX-44 IHN-CCO Drug Utilization Review (DUR) Policy
[xv] CSD-RX-27 Part D Medication Therapy Management Program Policy
[xvi] 2021 IHN-CCO Utilization Management and Service Authorization Handbook and Care Coordination Program
[xvii] CSD-CC-CM-53 IHN-CCO Transition of Care Policy
[xviii] American Society for Quality (ASQ) Quality Tools A-Z, Institute for Healthcare Improvement (IHI) QI Essentials Toolkit, and IHI PDSA Worksheet
[xix] CSD-QM-02 Chronic Care Improvement Program Policy
[xx] 42 CFR § 422.152(c)(1) Quality Improvement Program
[xxi] 42 CFR § 422.152(c)(1)(iv) Quality Improvement Program
[xxii] 42 CFR § 422.152(c)(2) Quality Improvement Program
[xxiii] 42 CFR 438.358 Activities Related to External Quality Review and 42 CFR 438.240 Quality Assessment and Performance Improvement Program
[xxiv] TQS Guidance Document
[xxv] AT-03 Commercial Appeals Policy, GA-03 Grievance-Complaint Policy, AT-02 IHN Appeals Policy, GA-02 IHN Grievance-Complaints Policy, AT-01 SAHP Appeals Policy, GA-01 SAHP Grievances Policy
[xxvi] QMC Charter
[xxvii] QIC Charter
[xxviii] Accreditation & Standards Taskforce Charter
[xxix] Member Experience Taskforce Charter
[xxx] Provider Network Taskforce Charter
[xxxi] SNPMOC Taskforce Charter
[xxxii] Population Health Taskforce Charter
[xxxiii] TQS Taskforce Charter
[xxxiv] Behavioral Health Quality Committee Charter
[xxxv] SHS Credentialing Committee Policy
[xxxvi] Dental Health Advisory Committee Charter
[xxxvii] P&T Committee Charter
[xxxviii] CSD-QM-10 Medicare Required HEDIS Reporting Policy and CSD-QM-18 HEDIS Medical Record Review Vendor Monitoring and Oversight Policy
[xxxix] 2022 Clinical Services Star Measures
[xl] SHS Equity and Inclusion Plan
[xli] CSD-QM-01 Quality Management Program Policy
[xlii] CP-11 HIPAA Security Policy and HIPAA Administrative Standards Policy - System