UMPQUA HEALTH

Health Equity Plan – Section-1

Health Equity Plan Strategy, Key Elements: Social Determinants of Health, Health Equity, and Community Engagement

Background

Umpqua Health Alliance (UHA) is deeply rooted in Douglas County, where we got our start. We have been serving Oregon Health Plan members for over 25 years. We are managed through a locally-based board of directors and Community Advisory Council (CAC) that ensures local healthcare needs are fully met.

UHA is governed within public meetings, where public members are encouraged to attend the entire meeting. Decision making is fully transparent, with an intentional connection to the CAC. Both the CAC Chair and Vice Chair sit on the UHA Board, with full voting rights. In 2020, UHA will have an OHP beneficiary on the governance board, with full voting rights.

UHA understands the importance of directly addressing the social determinants of health and the cultural, socioeconomic, racial, and regional disparities in health care that exist among our members and the broader community in Douglas County. Over the last three (3) years, Umpqua Health has invested over $1M in delivery system capacity, through community wellness, early childhood education, workforce development, Trauma Informed Care, crisis resolution, housing, and other efforts to address social determinants of health. Through the development and implementation of robust community engagement and SDOH-HE plans, informed by REAL+D data collection, UHA can continue to meet the needs of our members and the broader community in every corner of Douglas County, in a more targeted approach.

UHA's patient-centered, provider-led mission and values drive our community engagement approach. With a strong history of leadership in health care in Douglas County, UHA is driven by a common professional ethic to improve our patients' lives. We have the established community footprint, existing partnerships, and historical knowledge to drive a process that meaningfully engages the broad community in CCO decisions, activities, and deliverables that addresses regional, cultural, socioeconomic, and racial disparities in health care. In this regard UHA's VP of Transformation regularly participates in the Network-of Care community forum, which provides UHA an opportunity to support the concept of a single CHA and CHIP plan for Douglas County.

UHA currently engages in significant outreach and community focused programming intended to address social drivers of health. At present, UHA is involved in over 65 specific programs designed to positively impact health equity in Douglas County. These programs range from efforts to assist people who are experiencing, or who have experienced, domestic violence and other forms of trauma to work with farmers' markets and other programs designed to increase access to healthy foods. Programs to address challenges with transportation, housing, and early childhood education, social determinants that impact the health of individuals and communities in Douglas County, are also part of our footprint in the county. UHA participates in programming focused in the following areas:

- Efforts to reduce health disparities
- Efforts to reduce hospitalizations
- Efforts to promote wellness and health
- Efforts to improve economic stability
- Efforts to improve early childhood education
- Efforts to improve neighborhoods and built environments
- Efforts to improve community health
- General efforts to address social determinants

Specific programs operating in these areas can be found in the tables accompanying our community engagement plan.

Health Equity Plan Development and Implementation

A) Description of UHA's Work force and CAC demographics: UHA's workforce reflects gender diversity and a healthy mix of educational background, this trend is also reflected in the CAC member demographics (see tables below) – UHA's Workforce Development Plan (attached as addendum) has been designed to create greater opportunities for individuals from minority race and ethnic backgrounds.

UHA Employee Demographics		
Row Labels	Sum of Annual Salary	Count of Zip / Postal Code
Female	7879972.82	130
	1839652.73	30
	1839652.73	30
Associates	239001.49	5
Bachelors	353704.78	3
Doctorate and above	235000.08	1
High School/GED	235569.06	7
Masters	335101.36	3
Not indicated	144565.58	4
Some College	291711.2	7
Hispanic or Latino	344357.25	6
	344357.25	6
Bachelors	214695.06	3
High School/GED	88070.59	2
Some College	41591.6	1
Not Hispanic or Latino	5695962.84	94
White	5052125.82	84
Associates	1074147.71	17
Bachelors	890071.27	14
Doctorate and above	630799.44	3
High School/GED	674617.18	15
Masters	453976.56	5
Not indicated	406867.74	9
Some College	819531.52	21
	37878.26	1
Some College	37878.26	1
American Indian or Alaska Native	116018.08	2
High School/GED	38521.52	1
Some College	77296.56	1
Asian	279738.42	4
Associates	103862.08	2
Masters	117675.04	1
Not indicated	58002	1
Native Hawaiian or Other Pacific Islander	84401.48	2
High School/GED	50000.08	1
Some College	34401.4	1
Two or more races	115000.08	1

Male	5077416.1	42
	1619208	16
	1619208	16
Associates	109521.6	2
Bachelors	208584.56	4
Doctorate and above	495000.24	2
Masters	635000.16	5
Some College	171171.44	3
Hispanic or Latino	425115.36	2
	425115.36	2
Doctorate and above	265200	1
Not indicated	159915.36	1
Not Hispanic or Latino	3013092.74	24
White	2721119.39	20
Associates	230572.09	4
Bachelors	308447.81	4
Doctorate and above	1111083.4	4
High School/GED	61920.76	1
Masters	856767.58	4
Some College	127281.36	2
Some High School	25647.39	1
Asian	235010.39	2
Bachelors	60010.91	1
Doctorate and above	175000.08	1
Two or more races	78962.96	2
Associates	45761.76	1
High School/GED	31201.2	1
Grand Total	12457388.87	172

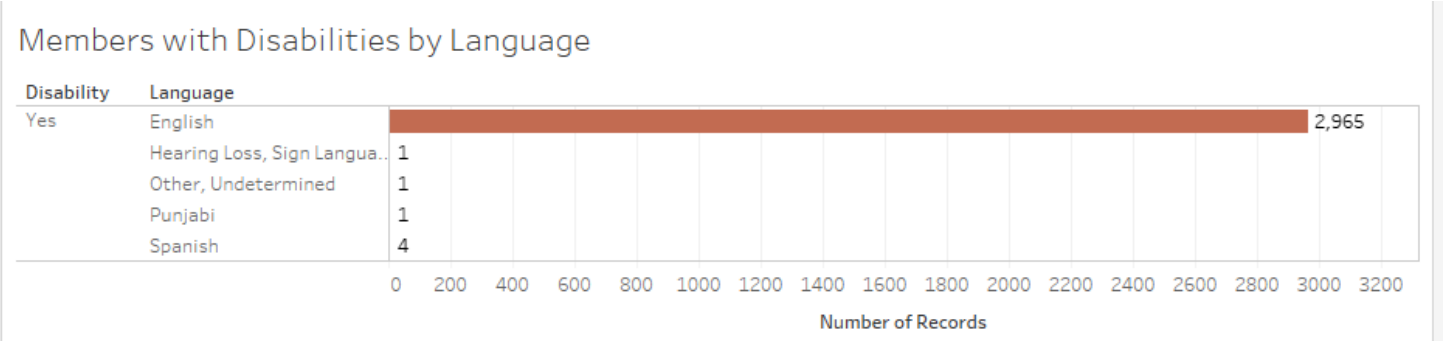
CAC Demographics:

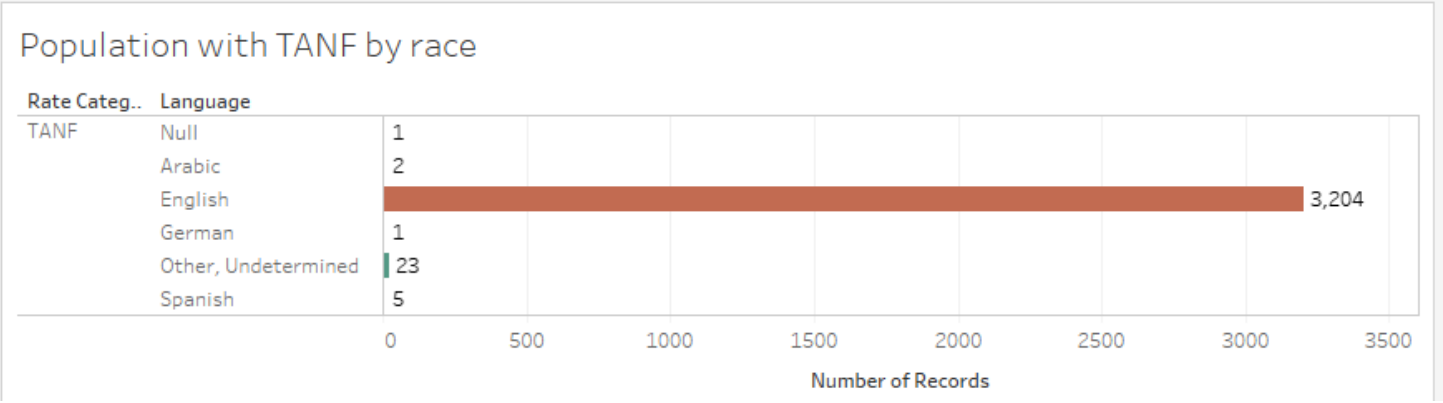
Education	Race	Gender	Language	Zip Code
Bachelor's	Caucasian	Female	English	97469
Bachelor's	Caucasian	Female	English	97471
High School	Caucasian	Female	English	97499
Master's	Caucasian	Female	English	97470
Master's	Caucasian	Male	English	97471
Master's	Caucasian	Male	English	97417
Bachelor's	Latina/Native American	Female	English	97471
Bachelor's	Caucasian	Female	English	97443
Master's	Caucasian	Female	English	97481
High School	Caucasian	Female	English	97470
Master's	Caucasian	Female	English	97471
Doctorate	Caucasian	Female	English	97470
High School	Caucasian	Female	English	97470
Doctorate	Caucasian	Female	English	97432

Description of UHA's service area consumers: The Medicaid population served by UHA is reflective of Douglas County's demographics with more than 90% identifying themselves as white – UHA has successfully developed a functional SDOH & REAL+D database, this data is being used to analyze Grievances and Appeals (see G&A report in addendum), the database receives info from the following data streams:

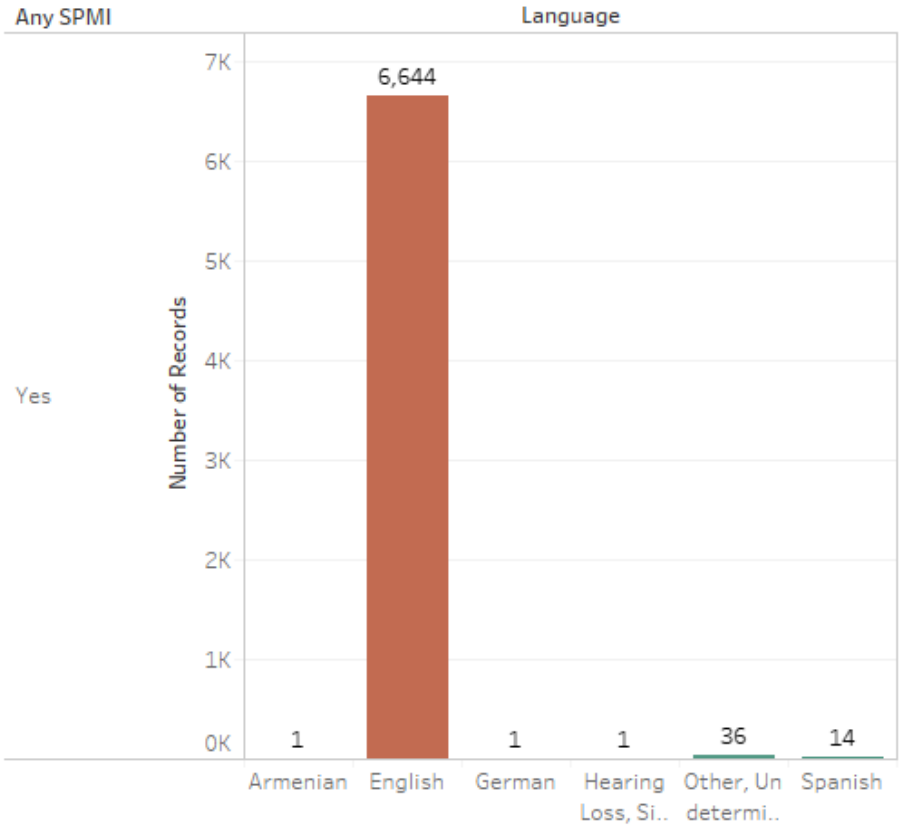
i. OHA Dashboard data [updated monthly]
ii. Umpqua Health BI platform [Quality metrics data]
iii. Children's Complexity file [ACES data]
iv. UHA Health Risk Assessment file [member reported data]

The database has been configured using the Tableau software framework, which provides versatility for cross spectrum data-analysis (see tables below):



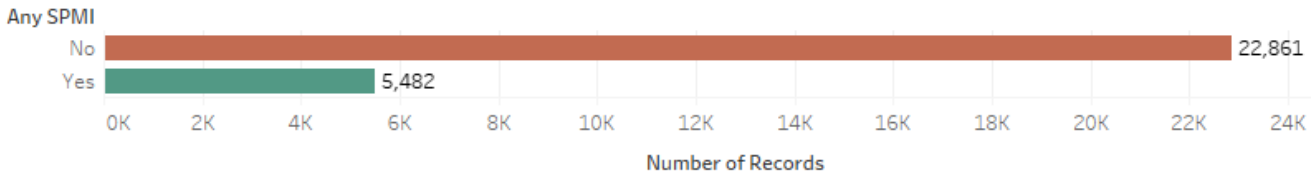


SPMI Population by Language



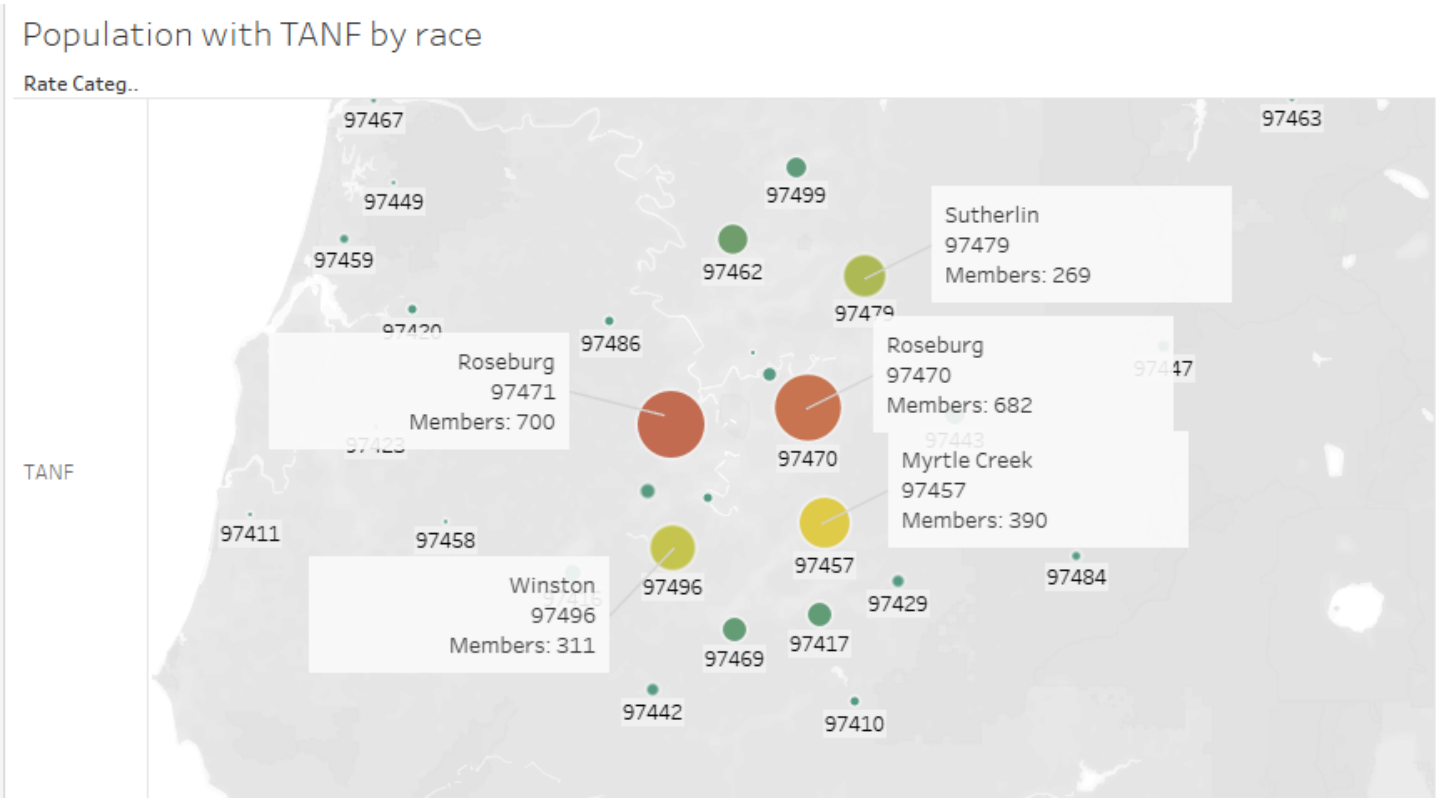
Total eligible population with SPMI

Approximately 19% of current population



SPMI with TANF

Any SPMI	Rate Categ..	
Yes	TANF	977



B) Organizational oversight and accountability: UHA Health Equity Committee has met three times this year; the committee is co-chaired by the HEA and the Cow Creek Band of Umpqua Tribal Government Representative on the UHA Board, UHA's executive team and the CAC Chair who is also a UHA Board member are committee members. The Committee has reviewed and provided feedback on the draft HE-Plan and associated deliverables. The Tribal Representative/Board Member has presented the plan framework in detail to the UHA Board. UHA, has also stood-up the Member Engagement & Health Equity Committee (MEHE), which is comprised of community stakeholders [Douglas County ESD; Ford Family Foundation; CEO of a Non-Profit helping individuals affected by domestic Violence and providing shelter to unhoused and displaced individuals, UHA Board Member, ED of Healthcare Coalition of Southern Oregon, UHA Staff with LGBTQ representation and County Public Health (DPHN)], this committee has also reviewed the HE-Plan in small group settings and provided useful feedback, the committee also receives updates from key UHA departments: Clinical advisory Panel/Quality Advisory Committee/Pharmacy & Therapeutics Committee/Member Services Department. As per OHA guidance UHA has expanded the MEHE committee to include representation from LGBTQ community, CBOs and Local Public Health; this has helped UHA to get better informed about community needs and receive feedback on the HEP. The MEHE and members of the Health Equity committee met in a special two hour session to review the draft HEP, the meeting format divided into a general session and smaller focus-group sessions; at the end of the sessions members were asked to complete a survey questionnaire which basically required responses on all sections of the HEP: the response rate was 67% and out of these 83% were fully satisfied with the structure of the HEP.

C) HE-Plan Development Process: UHA's HEA has constantly engaged the key stakeholders, Board members, MEHE Committee, CAC and the Tribal Government during the formulation of the HE-Plan. Due to Covid-19 it was not feasible to hold public meetings and focus groups, after evaluating the county level situation UHA will decide to hold such forums if a safe environment can be assured. Instead, as explained in section "B" above UHA expanded the MEHE committee and held a special session which included members of the MEHE and Health Equity Committees.

UHA prepares to meet Secondary Impacts of Covid-19, While addressing essential community needs:

The social and economic impact of Covid-19 has exposed inequities within our health care and social service systems. In Douglas County we have realized that there is a growing gap between the need for essential resources and the capacity to coordinate and meet those needs. While UHA along with community stakeholders and the Tribal Government respond to the immediate challenges, we are also committed to rebuilding these systems with sustainable solutions that address equity and social determinants of health.
In the month of June Douglas County's local legislator representative Gary Leif arranged a group listening session which included physical health providers, CCO HEA, mental health providers (CMHP), nonprofits focusing on domestic violence, food insecurity and homelessness - From these conversations, five major resource needs emerged:

- Food: Food distribution is more challenging due to joblessness, and dwindling staff and volunteers for programs.
- Mental health, substance, and abuse support: Resources are needed to address mental health challenges amplified by the pandemic, including stress, abuse, and neglect.
- Childcare: Childcare needs are more challenging to meet, especially for essential workers who are keeping others safe, and healthy.

HE-Plan Implementation Process, Timelines and Metrics

Baseline Assessment Activities

To determine the best strategies to improve community engagement and health equity outcomes, UHA will engage in the following activities to establish a baseline understanding of our current performance:

1. Conduct an assessment and gap analysis of UHA and our partners and providers to measure current:
   a. Level of community input and engagement
   b. Member engagement activities
   c. REAL+D data collection activities
   d. Culturally and linguistically specific member communication and engagement strategies
   e. Collection of data and understanding about social needs that impact members' health
   f. Training on CLAS and health equity
   g. Efforts to address community health and health equity
2. Conduct an external (members and community) environmental scan and assessment to identify:
   a. Priority community needs and beliefs about community health and health equity
   b. Community priorities around community health and health equity
   c. Existing and potential community partners to improve community health and health equity
   d. Existing best practices for improving access, collecting and utilizing REAL+D data for quality improvement, and improving health and reducing disparities.

Once baselines are established, UHA will engage in efforts to improve community health and health equity by engaging in strategies identified in the internal and external assessments as well as the following efforts:

Goal 1: Collection and Use of Race, Ethnicity, Language, and Disability; Health-Related Social Needs; and Social Determinants of Health Data to Improve Quality and Community Health By December 2020, UHA will improve its organizational capacity to collect and use REAL+D, health-related social needs, and social determinants of health data to identity and address health disparities and to improve community health in Douglas County.

Strategy 1: Develop robust processes, tools and technologies to collect and analyze REAL+D data

Tactics

Tactic 1.a.: Starting in Q3 2019, UHA's Quality Improvement Department will identify priority indicators for tracking data based on current research and community priorities.

Tactic 1.b.: In Q2 2020, UHA's Quality Improvement Department will identify best practices and technologies for collection, storage, and sharing of member REAL+D while respecting patient privacy and legal requirements, including documentation in electronic health records, through health risk assessments, etc.This evaluation will alsoinclude a recommendation of using REAL+D standards in business processes.To ensure proper oversight, by Q3 2020 the Quality Improvement Department will present best practice recommendations to the Quality Advisory Council for consensus.

Tactic 1.c: In Q4 2020, develop and execute necessary data sharing agreements with partners and providers to support a robust data collection and reporting system that includes REAL+D data. During this time, the Quality Improvement Department will identify and develop dissemination of data timeframes, including frequency and mode of transmission.

Tactic 1.d: Develop and implement a plan for using member REAL+D data for disaggregation of key quality metrics by demographic characteristics. The Quality Advisory Committee will identify at least three quality measures for analysis and quality improvement as part of transformation and quality strategy (TQS).

Tactic 1.e. The three quality measures will be identified and reviewed with the Quality Advisory Council on a quarterly basis to ensure health disparities are being identified as anticipated, and updated as needed.

Tactic 1.f. Provide an annual report to the Quality Advisory Council monitoring the usage of REAL+D data and the impact on UHA's quality improvement initiatives, community health, and member experience.

Tactic 1.g. The Quality Improvement Department will evaluate the plan of collection and usage of REAL+D. and related business processes, annually and adjust as needed.

Timeline for Strategy 1

Strategy: Data Infrastructure Development and Implementation

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 1.a: Identify priority indicators	»		X																			
Tactic 1.b: Identify and implement best practices data collection				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 1.c: Develop and execute data sharing agreements				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 1.d: Develop plan for using health disparities data, outcome evaluation activities by demographic data						»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 1.e.: Quality measures reviewed at Quality Advisory Committee							»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 1.f.: Annual report											»	X			»	X			»	X		
Tactic 1.g.: Annual evaluation										»	X			»	X			»	X			»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 1

UHA will assess this strategy by reporting the types of REL+D data collected and the number of active data sharing protocols to support the collection of REAL+D data. UHA will identify which quality measures have been analyzed using REAL+D data.

Strategy 2: Identify and implement best practices, tools, and technology for tracking health care and social needs/social determinants data (e.g. risk stratification tools, community resource and referral database, referrals to social services, tracking of social needs met)

Tactics

Tactic 2.a.: Establish and implement data collection protocols based on best practices for collecting health care and social needs data

Tactic 2.b.: Develop and implement a process for sharing reports or raw data with SDOH-HE partners and other relevant stakeholders, including a plan to address patient privacy concerns

Tactic 2.c: Provide data and reports/raw data to partners and relevant stakeholders.

Timeline for Strategy 2

Strategy: Identify and implement best practices for social needs data collection

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 2.a: Establish Protocols	»	X																				
Tactic 2.b.: Reporting Protocols	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 2.c.: Report Sharing					»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 2

UHA will assess this strategy by documenting the existence of protocols and ongoing data collection to track social needs referrals and health outcomes, as well as patient privacy. Additionally, UHA will document the frequency and purpose of use the data and all related outcomes.

Goal 2: Workforce Diversity and Inclusion Plan

UHA will recruit, retain, and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of Douglas County by June 30, 2020.

Strategy 3: Develop and implement a workforce diversity and inclusion plan

Tactics

Tactic 3.a.: Designate or hire a Health Equity Officer who is accountable to UHA's leadership for overseeing the development, implementation, and evaluation of the plan, in order to enhance UHA's organizational capacity to advance health equity, as described in Goal 3.

Tactic 3.b.: Create or designate a committee comprising community stakeholders, community leaders, and partners to work with the CAC and the Health Equity Officer to inform the workforce diversity plan and approach.

Tactic 3.c.: Develop policies to recruit, promote, retain, and support a culturally and linguistically diverse governance, leadership and workforce. This may require assessing UHA's structure and governance in addition to hiring procedures.

Tactic 3.d.: Develop processes and practices for advertisement of job opportunities and recruitment using channels that have a diverse audience such as minority health professions groups and foreign language/diversity publications.

Tactic 3.e.: Put systems in place to continually assess staff demographics and promotion demographics.

Tactic 3.f.: Develop employee performance evaluation systems that include criteria for cultural and linguistic competency goals.

Timeline for Strategy 3

Strategy: Develop and implement a workforce diversity plan

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 3.a.: Designate Health Equity Officer	»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 3.b: Establish Health Equity Committee			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 3.c: Develop policies to promote diverse workforce			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 3.d.: Develop recruitment strategies			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 3.e.: Put systems in place to assess demographics			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 3.f.: Develop performance evaluation systems			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 3

UHA will measure success of this strategy by ensuring a workforce diversity plan that includes a mechanism to collect and processes for tracking key information on an annual basis. Additionally, UHA will document the Health Equity Officer and Health Equity committee progress on the implementation of the plan through committee reporting on a quarterly basis.

Goal 3: Health Equity Plan

By December 2020, UHA will enhance its organizational capabilities regarding health equity through the development and implementation of a health equity plan.

Strategy 4: Review, assess, and make appropriate changes to organizational structure including the designation of a Health Equity Officer and the establishment of a health equity committee to work with leadership and all functional areas of UHA to develop a health equity plan that will be applied across the organization, both internally and externally.

Tactics

Tactic 4.a.: Establish health equity committee and collect input from and engage the CAC, Clinical Advisory Panel, and other community stakeholders in the development of a health equity plan.

Tactic 4.b.: Identify a tool for an organizational assessment of health equity; implement the tool to establish a baseline and identify areas for improvement.

Tactic 4.c.: Develop a health equity plan that addresses grievances and appeals, demographic data collection, language and communication assistance services, member communications, culturally and linguistically appropriate services, workforce diversity, staff and provider training and education, with strategies, objectives, activities, policies, timelines, and measures of success.

Tactic 4.d.: Present the health equity plan to the CAC, Clinical Advisory Panel, and other community stakeholders for feedback and to Board of Directors for approval; share with provider network and community stakeholders.

Timeline for Strategy 4

Strategy: Make organizational structure changes needed to develop a health equity plan

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 4.a: Establish health equity committee			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 4.b: Assess and address organizational structure needs	»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 4.c: Develop health equity plan as required by the CCO contract		»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 4.d.: Board and CAC Approval; share with Provider Network			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation for Strategy 4

UHA will measure success of this strategy by documenting and ensuring appropriate structure to lead and have accountability for the development and implementation of the health equity plan. UHA will document the distribution of the health equity plan.

Strategy 5: Implement the health equity plan.

Tactics

Tactic 5.a.: Use demographic data beyond what UHA receives from OHA to inform approached to health equity work included in the health equity plan.

Tactic 5.b.: Assess existing language access and accessibility services and create a measurement plan to monitor the quality of translation services. Develop an evaluation system to assess the best way to address the sharing of material in alternate formats, including testing materials with target audiences. Adopt Culturally and Linguistically Appropriate Services (CLAS) standards as an organization and encourage or require partners, delegates, and providers to adopt CLAS standards. Ensure the plan includes steps for compliance with federal and state laws regarding language access (ACA 1557 and Title VI) and ADA.

Tactic 5.c.: Assess workforce training and provider network needs around cultural competency and responsiveness and implicit bias; develop a plan to address those needs with short-term and long-term goals.

Tactic 5.d.: Integrate CLAS into continuous quality improvement (CQI) processes (e.g., organizational assessments, CLAS-oriented surveys for consumers, focus groups with staff and consumers to identify barriers to CLAS implementation, CLAS-related questions in staff orientation materials and yearly reviews)

Tactic 5.e.: Review all organizational policies and procedures using the health equity lens.

Timeline for Strategy 5

Strategy: Make organizational structure changes and develop a health equity plan

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 5.a: Use demographic data to inform the health equity plan	»			X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 5.b: Assess language and accessibility services; create plan to monitor				»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 5.c: Assess workforce and provider network training and needs on cultural competency; develop plan to address				»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 5.d: Integrate CLAS into CQI processes				»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 5.e.: Policy and procedure revision using health equity lens					»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 5

UHA will document the development of the health equity plan and report outcomes to relevant governance committees on a quarterly basis. UHA will engage in a quality improvement process around the health equity plan and adjust the plan as necessary to achieve the desired results.

Goal 4: Community Engagement Plan

UHA will develop a community engagement plan that involves broad and meaningful community engagement, and that addresses regional, cultural, socioeconomic and racial disparities in health care across Douglas County by September 30, 2020.

Strategy 6: Identify, assess, and address barriers to community engagement.

As part of its global approach for implementation, UHA will deploy the Policy, Systems and Environmental (PSE) process approach in its operations and decision making. Specifically, UHA will utilize data at every stage of the seven steps:

Step 1: Engage - Build Partnerships and Engage the Community

Step 2: Scan - Perform Environmental Scans

Step 3: Assess - Identify Priority Areas

Step 4: Review - Assess Feasibility of Interventions

Step 5: Promote - Promote Awareness, Communicate and Educate

Step 6: Implement - Take Action

Step 7: Evaluate - Measure Success

Tactics

Tactic 6.a.: Develop a survey to solicit feedback on regional, cultural, socioeconomic and racial disparities for members and community stakeholders. UHA's Health Equity Officer will identify relevant community stakeholders that should participate in the survey process. Survey will provide input on barriers and potential opportunities for community engagement, including but not limited to, participation in CAC meetings and public board meetings, and develop a process to gather feedback from the broader community about barriers to, and opportunities for, engagement. Surveys will be made available in Spanish, along with alternative languages and formats upon request. Lastly, UHA will utilize additional methods to obtain member feedback (see Tactic 6.c).

Tactic 6.b.: Review industry data on Douglas County to identify potential barriers that members may not volunteer in a survey, such as literacy level, language barriers, accessibility for people with disabilities, transportation challenges, and the need for a trauma-informed approach. Additionally, UHA will review its own internal data that it has received directly from its members and providers. Such data elements will include information obtained through grievance, appeals, health risk surveys, assessment, discharge plans, transitions of care documentation, etc.

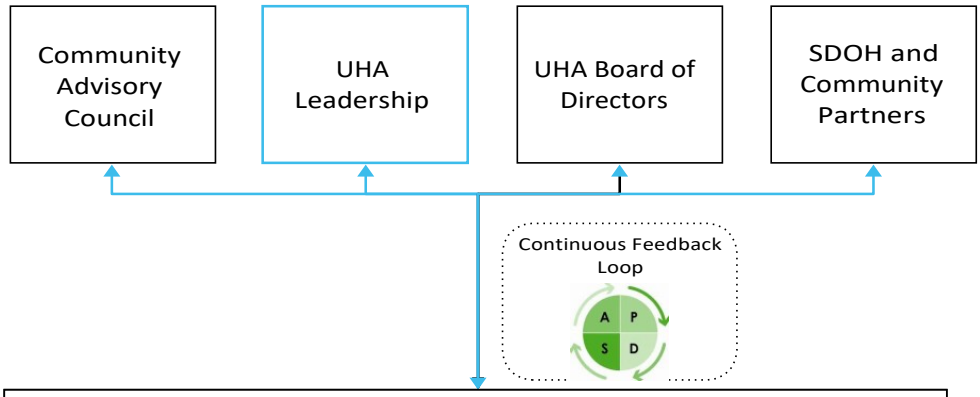
Tactic 6.c: Hold annual focus groups/town hall for members and community stakeholders to provide feedback in an open forum on regional, cultural socioeconomic and racial disparities in Douglas County. UHA will make available certified interpreter services, auxiliary aides, etc. to assist members and participants in hearing and receiving feedback.

Tactic 6.d: Provide training, conducted by an industry expert, to the CAC on the regional, cultural, and socioeconomic and racial disparities in health care in Douglas County to ensure CAC decision aligns with addressing known disparities.

Tactic 6.e: Set aside a CAC funding each year of monies identified from OHA's SHARE Initiative Program, that will be used to address specific health disparities identified through earlier assessments.

Tactic 6.f.: Incorporate feedback from Tactics 6.a and Tactic 6.b into the community engagement plan, on the actionable steps required to address the identified regional, cultural, socioeconomic, and racial disparities, including a timeline for making changes and how UHA will be held accountable for them. Adjust annually, as necessary, based on feedback from focus groups/town halls.

Tactic 6.g: Create a Health Equity Committee that is led by the Health Equity Officer and made up participating member organization. Specifically, the Committee will be made up of representation from the CAC, UHA Board of Directors, UHA Leadership, SDOH and Community partners (e.g.Tribal representation and minority/ religious stakeholders) and groups defined based upon Gender-Identity. The Health Equity Committee will oversee and guide the work of UHA's Member Engagement and Health Equity Operational Committee which will focus initially on the following domains: 1) Community Engagement (with the lens of health equity), 2) Cultural and Linguistic specific member materials and access to services, 3) Health Equity data, and 4) Training and Education. The Health Equity Committee will inform its work through a continuous feedback loop to its respective participating organizations on strategies, tactics, and outcomes of addressing health disparities in Douglas County.



Health Equity Committee

- Participating Member Organizations: CAC, UHA Board of Directors, UHA Leadership will each provide individuals to sit on the Health Equity Committee
- Co-Chairs: Tribal Government/Board Member and UHA's Health Equity Administrator

Scope of Committee

- Identify global strategies to identify and address health equity in Douglas County.
- Provide framework on approach to solicit feedback from members on regiona,l cultural, socioeconomic and racial disparitie.s
- Identify and support resources to address health disparities.
- Review industry data and UHA internal data on health equity and disparities
- Provide information to Participating Member Organizations on the impact of disparities and strategies and tactics to addresshealth equity in the community.
- Overall oversight and monitoring of UHA's approach to assess regional, cultural, socioeconomic,and racial disparities.

Member Engagement and Health Equity Operational Committee

Participants: UHA Internal Staff, CAC Members, SDOH and Community Partners ,
Chair: UHA's Health Equity Administrator

Scope of Committee

- Implement and operationalize tasks identified by the Health Equity Committee.
- Report to the Health Equity Committee on progress and activities implemented.
- Collect industry data and UHA specific data on member engagement and on regional cultural, socioeconomic, and racial disparities, and present to Health Equity Committee.
- Engage in tasks to solicit feedback directly from members and community stakeholders (not limited to surveys, town halls, listening groups, etc.)
- Ensure availability of content in other languages, alternative formats, etc.
- Design and distribute member engagement information (not limited to newsletters, educational materials, benefit information, etc.) to elevate member and community voice.
- Respond to and implement processes to address feedback from community with regards to member engagement opportunities or means to reduce health disparitie.s
- Committee will centralize work in the following domains:
  - Community Engagement
  - Cultural and language specific materialand accessibility of those services
  - Health equity data
  - Training and education

Timeline for Strategy 6

Strategy: Identify, assess, and address barriers to broad community engagement

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 6.a: Develop and field survey	»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 6.b: Assess barriers in broader community		»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 6.c: Conduct focus groups/town halls			»	»	X		»	»			»	»	X		»	»	X		»	»	X	
Tactic 6.d: CAC training			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 6.e: CAC dedicated funding							»	»	»	X	»	»	»	X	»	»	»	X	»	»	»	X
Tactic 6.f: Incorporate steps into the plan				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 6.g: CAC work group				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 6

UHA will send a follow-up survey and periodically communicate with CAC members and community stakeholders to describe the steps taken to address barriers and to seek feedback on how successfully UHA has done so. UHA will track survey results over time. UHA, will develop specific, measurable, attainable, relevant and time-bound (SMART) objectives for the PSE interventions.

Strategy 7: Develop a clear plan for varying levels of meaningful community engagement from UHA members and non-members that addresses a broad set of UHA decisions, activities and deliverables that are not limited to the CHA/CHP process.

Tactics

Tactic 7.a.: By Q4 2019, UHA will conduct an internal assessment of opportunities for member and community engagement in UHA activities and operations. UHA will identify other opportunities in which its members and community congregate and begin to participate in those opportunities in order to gain a more holistic viewpoint. Additionally, UHA will identify additional opportunities to solicit feedback from members such as an expanded CAC, public listening sessions, town halls, participation in and sponsorship of community events, and its new Member Engagement Committee (see Strategy for Quality- Member Engagement and Health Equity Committee).

Tactic 7.b.: Beginning in Q4 2019, UHA will conduct an analysis or environmental scan of community stakeholders to identify groups or voices that may be missing or underrepresented in community engagement. UHA will extend invitations to those groups to participate in UHA's CAC and Member Engagement and Health Equity Committee. Additionally, UHA will also engage the stakeholders to see if there are groups or committees they administer in which they would like UHA to participate in. As UHA engages the community, the following values will guide the work: transformation, equity, inclusion, and transparency. By doing so, UHA will include organizations or groups that may have members in Douglas County but not an official county chapter to fill in gaps, including racial and ethnic minorities, LBGTQ Oregonians, and organizations that support individuals battling substance use disorders and behavioral health disorders.

Tactic 7.c: Review and revise the governance structure as appropriate to ensure that the CAC is truly reflective of UHA's membership and the broader community, that there is sufficient member and CAC representation on the UHA Board, and that a strong mechanism, or feedback loop, is in practice to allow for bidirectional communication and implementation of CAC recommendations.

Tactic 7.d: Ensure the document process for selection of two CAC members on the UHA governing board, one of which is on OHP member. CAC members who sit on the UHA governing board are fully engaged as voting members with decision-making authority.

Timeline for Strategy 7

Strategy: Develop a clear plan for engagement from members and non-members across many functions

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 7.a: Internal assessment		»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 7.b: Analyze stakeholder landscape		»		X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 7.c: Review and revise governance structure	»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 7.d: Board representation	»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 7

UHA will develop a clear definition of "meaningful engagement" to support the development of a baseline measure of engagement opportunities. UHA will track changes in the number of engagement opportunities over time. Additionally, UHA will identify priority communities for engagement strategies and collect qualitative data from town halls and community events to track changes in barriers around engagement.

Strategy 8: Develop a means to share the community engagement plan and annual updates publicly.

Tactics

Tactic 8.a.: By First Quarter 2020, share the community engagement plan at the CAC meetings, Member Engagement and Health Equity Committee, and Board of Directors to develop a process for sharing the plan with the broader community. Develop a method to evaluate the effectiveness of distribution.

Tactic 8.b.: Implement and distribute the plan. Distribution approaches to include press releases, social media, the UHA website, community events, UHA Member Newsletter, UHA Provider Newsletter, public forums, and leveraging stakeholder partners who communicate regularly with their memberships

Tactic 8.c: Conduct an annual (in years 2021, 2022, 2023 and 2024) assessment to check the broader community's familiarity with the engagement plan and effectiveness of the engagement plan. Adjust and communicate as needed to reach a larger audience.

Tactic 8.d: Present to the CAC and UHA Board of Directors on an annual basis a report showing who the plan was shared with, feedback, and the approach for making necessary adjustments.

Timeline for Strategy 8

Strategy: Develop a means to share the community engagement plan and annual updates publicly.

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 8.a: Plan to share with the broader community		»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 8.b: Implement distribution plan to share publicly		»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 8.c.: Conduct annual assessment						»	X			»	X			»	X			»	X			
Tactic 8.d.: Annual Board reporting							»	X			»	X			»	X			»	X		

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 8

UHA will compare distribution approaches to best practices. Additionally, UHA will collect feedback via survey from stakeholder organizations to determine if they and their memberships/communities are aware of the plan.

Goal 5: Social Determinants of Health Community Engagement Process

Develop a transparent and equitable SDOH-HE funding approach that includes strategies, policies and/or procedures for ensuring transparency in the process of awarding funding for SDOH-E projects and the outcomes of funded projects by December 31, 2020.

Strategy 9: Strengthen outreach strategies beyond CCO staff and CAC dissemination, to ensure funding opportunities are disseminated broadly and reach new potential partners, including culturally specific organizations and community partners that serve marginalized populations.

Tactics

Tactic 9.a.: Conduct a baseline assessment of current marketing and dissemination strategies for funding announcements and bidder resources.

Tactic 9.b.: Identify additional priority communities and partners based on health disparities and needs data collected through the CHA, CHP and other sources.

Tactic 9.c.: Engage in expanded outreach strategies and/or specific funding set asides to build and strengthen relationships with priority communities and address priority needs. Identify opportunities to engage in reciprocal work with organizations and communities identified as priority recipients of outreach strategies.These can include community health efforts, advisory boards, or direct outreach to relevant staff of community organizations to provide information about resources and funding opportunities.

Timeline for Strategy 9

Strategy: Develop a clear plan for engagement from members and non-members across many functions

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 9.a.: Baseline assessment				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 9.b: Identify additional priority community and partners					»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 9.c: Engage in expanded outreach with priority communities						»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 9

UHA will track changes in the number and types of grantees applying for funds. UHA will track the number and types of communities served in applications for funding and changes in outcomes related to priority communities.

Strategy 10: Establish and/or detail set criteria for project evaluation in order to ensure fairness and reduce bias. Establish criteria using a public, transparent process, such as through the CAC.

Tactics

Tactic 10.a.: Conduct a baseline assessment of past grantees programming type, geographic location, communities served, and funding amount.

Tactic 10.b.: Conduct key informant interviews with past awardees serving culturally specific communities to understand successes and barriers to engaging SDOH-HE funds.

Tactic 2 10.c.: Conduct a review of past applicants serving culturally specific communities that were not awarded funds to identify barriers.

Tactic 10.d.: Conduct a review of funding criteria that ensures bias based barriers are removed and develop additional criteria that will allow for a broader range of funding recipients.These can include opportunities for funds to support program development and improvement and staff capacity development.

Tactic 10.e.: Develop a funding plan and timeline for implementation of new outreach strategies and criteria.

Timeline for Strategy 10

Strategy: Develop a clear plan for engagement from members and non-members across many functions

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 10.a: Conduct baseline assessment				»	X																	
Tactic 10.b: Conduct key informant interviews				»	X																	
Tactic 10.c: Review past applications				»	X																	
Tactic 10.d: Review funding criteria to ensure bias based barriers are removed					»	X																
Tactic 10.e: Develop funding plan and timeline					»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 10

UHA will track changes in the number and types of grantees awarded funds. UHA will track the number and types of communities served by grantees awarded funding.

Strategy 11: Clarify how organizations seeking funding can identify any conflicts of interest.

Tactics

Tactic 11.a.: Develop a clear and concise conflict of interest policy for dissemination to communities and potential grantees. Include in the policy how conflicts of interest are addressed, where to find updated information about current funding processes and stakeholders to assist potential grantees in identifying conflicts of interest.

Tactic 11.b.: Make available the conflict of interest policy through the web and email.

Tactic 11.c.: Make supporting information about processes and stakeholders easily accessible to potential grantees working to identify possible conflicts of interest.

Timeline for Strategy 11

Strategy: Develop a clear plan for engagement from members and non-members across many functions

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 11.a: Develop conflict of interest policy					»	X																
Tactic 11.b: Make conflict of interest policy readily accessible					»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 11.c: Make supporting information about processed and stakeholders easily accessible						»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 11

UHA will track the existence of a conflict of interest policy and accessibility of additional supporting information.

Strategy 12: Develop a housing investment strategy, including metrics that measure success of strategy.

Tactics

Tactic 12.a: Develop a logic model or similar program theory to articulate the expected impact of a housing investment on the health of the community and on UHA members, based on UHA's experiences, partner experiences, and best practices in the literature around health and housing. Interview partners and conduct a literature review to develop the program theory.

Tactic 12.b: Identify or develop metrics that will assess impacts of housing investments on housing stability, affordability, and health.This could include avoidable hospitalization due to reductions in asthma as a result of improving living conditions, reduction in jail bookings, or reduction in active homelessness, for example.

Timeline for Strategy 12

Strategy: Develop a housing investment strategy

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 12.a: Develop logic model to articulate expected impact of housing investments					»	X																
Tactic 12.b: Identify and develop metrics to assess impacts of housing					»	X																

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 12

Identify baseline data and develop a process for collecting data post-intervention.

Goal 6: Traditional Health Worker Expansion

UHA will build on its existing partnership to expand its work through Douglas County and build new and diverse relationships that can advance the capacity and availability of Traditional Health Workers (THWs) to promote health equity across the service area by September 30, 2020.

Strategy 13: UHA will work with existing and new partners, including community stakeholders, to design a THW Integration and Utilization Plan. The plan will drive efforts to publicize currently available services; increase its recruitment and retention of THWs in its operations, including through payment strategies; and include strategies to expand THW services beyond behavioral health.

Tactics

Tactic 13.a.: Conduct a baseline assessment of currently available THW services, geographic availability, and communities being served for all five worker types.

Tactic 13.b.: Develop outcomes for THW expansion of each worker type into additional geographic areas.

Tactic 13.c.: Develop clear policies and procedures for the engagement and utilization of THWs and compile these resources into a readily accessible format for access by provider network, members, and internal staff. Include payment policies, such as the THW payment grid modeled after the one developed by the THW Commission, and publish them on the UHA website.

Tactic 13.d.: Develop and implement a communication plan for ensuring providers and members are aware of the availability of THWs across the county, including communications around the scope of practice, available services, and policies and processes around access and utilization. Ensure the member handbook includes clear information about how to access the services of all five worker types of THWs.

Tactic 13.e.: Develop and implement an outreach plan for the recruitment and retention of traditional health workers to increase availability, available services, and community access to relevant health resources and professionals.

Timeline for Strategy 13

Strategy: Develop a THW Integration and Utilization plan

	2019		2020				2021				2022				2023				2024			
	QUARTER		QUARTER				QUARTER				QUARTER				QUARTER				QUARTER			
	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Tactic 13.a: Internal assessment and outcome identification			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 13.b: Develop outcomes for THW expansion			»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 13.c: Develop policies for THW engagement				»	X	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 13.d: Develop and implement communication plan						»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»
Tactic 13.e: Develop and implement recruitment and retention plan for THWs						»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»	»

» Anticipated Start Date X Anticipated Completion Date » Ongoing Effort

Evaluation of Strategy 13

UHA will create a baseline measure of current THW resources, their geographic availability, and demand/use data. Over the course of the contract going forward, UHA will track changes in the number of THWs, changes in geographic location, and increased use of THWs within specific communities.

SECTION-2

Section-2
Umpqua Health Alliance

CCO 2.0 Health Equity Plan Section 2
Health Equity Plan Focus Areas Goals, Objectives, and Measures of Success (minimum 10 pages, 12-point Arial font, single space)

Focus Area 1 Grievance and Appeals

OHA Expectations

The CCO Grievance and Appeal System policies and procedures are specifically designed to be culturally and linguistically appropriate. They fully comply with state and federal laws (Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, Title III of the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973). The CCO grievance process is simple, accessible, and understandable to the member. Literacy and language access (including alternative formats) are considered in the development of the process, and the development of the policies. Data on grievance and appeals is reported by race/ethnicity, language, and disability (READL).
CCO Contract Exhibit B Part 4 Provider and Delivery Systems (2)(g) and (2)(h) and (2)(i) and (2)(j)
CCO Contract Exhibit I General System Requirements (1)(e) and (2)(b) and (2)(f)
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(a)

Umpqua Health Alliance Policies and Procedures

- [see addendum for grievance and appeals policies and procedures]
- Member handbook informing members about right to grievances and appeals: https://www.umpquahealth.com/wp-content/uploads/2020/02/january2020-uhahandbook-vs-20.6.4.pdf (pages 8-9, 22, 25, 57-59)
- Website information about grievance and appeals, including member complaint form: https://www.umpquahealth.com/wp-content/uploads/2020/03/umpqua-health-alliance-complaint-form.3.9.20.pdf and primary care physician change request form: https://www.umpquahealth.com/wp-content/uploads/2019/12/pcp-change-request-form.12.13.19.pdf

Umpqua Health Alliance Focus Area 1 Strategic Goal(s)

By December 2024, Umpqua Health Alliance will implement system and process improvements to ensure that members can file and receive resolution of grievances and appeals in a culturally and linguistically appropriate manner.

Background and Context

CLAS Standard 14 is: “create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints,” in order to “facilitate open and transparent two-way communication and feedback mechanisms between individuals and organizations”, “anticipate, identify, and respond to cross-cultural needs”, and “meet federal and/or state level regulations that address topics such as grievance procedures, the use of ombudspersons, and discrimination policies and

procedures". The Blueprint for Advancing and Sustaining CLAS Policy and Practice[1] explains:

> Culturally and linguistically appropriate conflict and grievance resolution processes address the discrimination and unfair treatment - actual and perceived - of diverse populations. Discrimination based on race, ethnicity, sex, age, socioeconomic status, sexual orientation, gender identity, and other characteristics impede the provision of quality care and services, making culturally and linguistically competent conflict prevention and resolution a vital part of advancing health equity.
>
> Individuals from diverse backgrounds may encounter situations in which their needs and preferences are not accommodated or respected by the organization or its staff. These situations may range from differences related to informed consent and advance directives, to difficulty in accessing services or denial of services, to discriminatory treatment (HHS OMH, 2001). While personal preferences for care should be accommodated as much as possible and equitable nondiscriminatory treatment should be guaranteed, it is inevitable that individuals will have conflicts and grievances. To address this, organizations should ensure that all staff members are trained to recognize and prevent these potential conflicts and must develop a method through which individuals can provide feedback. All individuals must then be informed about, and have access to, these feedback procedures that cover all aspects of their interaction with the organization (HHS OMH, 2001)….
>
> Health and health care organizations should not assume that a lack of conflict or complaints equates to satisfaction with services or care provided. Individuals may have fears or cultural beliefs that inhibit criticism or may not know that they have the right to provide feedback. Individuals may also believe that feedback will be disregarded by the organization. Thus, in anticipation of individuals who are not comfortable with expressing or acting upon their own concerns, the organization should have both formal and informal procedures to solicit feedback.

The Blueprint for Advancing and Sustaining CLAS Policy and Practice suggests these implementation strategies:

- Provide cross-cultural communication training, including how to work with an interpreter, and conflict resolution training to staff who handle conflicts, complaints, and feedback.
- Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance.

[1] https://thinkculturalhealth.hhs.gov/clas/blueprint

- Develop a clear process to address instances of conflict and grievance that includes follow-up and ensures that the individual is contacted with a resolution and next steps (QSource, 2005).
- Obtain feedback via focus groups, community council or town hall meetings, meetings with community leaders, suggestion and comment systems, open houses, and/or listening sessions.
- Hire patient advocates or ombudspersons (QSource, 2005).
- Include oversight of conflict and grievance resolution processes to ensure their cultural and linguistic appropriateness as part of the organization's overall quality assurance program.

Umpqua Health Alliance Focus Area 1 System Elements and Data Streams
Umpqua Health Alliance will continue to engage its member services and provider network staff in implementing this strategic goal. Quantitative and qualitative data about grievances and appeals will continue to be collected and analyzed on a quarterly basis, including stratification by member race, ethnicity, language, and disability status, and analysis for themes and trends, e.g. grievances about language assistance services.

Umpqua Health Alliance Focus Area 1 Internal and External Resources Needed
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 1 Measures for 2020 and Plan for Updates and Revisions

- By June 2020, Umpqua Health Alliance will start analyzing Grievance & Appeals based on REAL+D data

- By August 2020, Umpqua Health Alliance will start planning improvement processes based on REAL+D data

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 1 will be monitored by the Health Equity Administrator (HEA).

Focus Area 2 Demographic Data

OHA Expectations
The CCO uses demographic data to advance health equity. The CCO makes demographic data collection and analysis a strategic priority. The CCO assesses gaps in its current data collection, analysis systems, and process, and develops organization-wide actionable goals to address them.

Section-2
Umpqua Health Alliance

CCO Contract Exhibit B Part 4 Provider and Delivery Systems (4)(a) and (b) and (c)
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(b)

Umpqua Health Alliance Policies and Procedures

- [see addendum for policies and procedures relevant to data collection]

Umpqua Health Alliance Focus Area 2 Strategic Goal(s)
By December 2024, Umpqua Health Alliance will integrate the collection and analyses of member race, ethnicity, language, and disability (REAL+D) data into its quality improvement and health equity goals and activities.

Background and Context
CLAS Standard 11 is: "collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery" in order to: "accurately identify population groups within a service area", "monitor individual needs, access, utilization, quality of care, and outcome patterns", "ensure equal allocation of organizational resources", "improve service planning to enhance access and coordination of care" and "assess and improve to what extent health care services are provided equitably". The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> The availability of demographic data, particularly race and ethnicity, is the first step in being able to demonstrate the effectiveness of CLAS in the delivery of quality, equitable care and, ultimately, in reducing disparities (Hasnain-Wynia & Baker, 2006; Nerenz, 2005; HHS, 2011b)….
>
> To ensure the accuracy and reliability of the data collected, organizations should facilitate processes that allow for self-identification and avoid use of observational/visual assessment methods, the latter of which is considered to be less reliable (Hasnain-Wynia & Baker, 2006; Hasnain-Wynia, Pierce, & Pittman, 2004; Higgins & Taylor, 2009). If a demographic variable (e.g., race) has more than one category, individuals should be allowed to indicate all categories that apply. In addition, with the increased adoption of health information technology, organizations have another way to improve upon the collection and exchange of reliable data (IOM, 2009)….
>
> Organizations may use demographic data to determine basic information about trends in organizational and health care utilization, such as the total number of visits made to emergency departments based on race/ethnicity and gender or the total number of individuals requesting language assistance. This information could then be used to make staffing assignment decisions or determine the need for additional language assistance resources. When linked with other data, health and health care

> organizations can make increased data-informed decisions and improve the quality of care, consistent with quality improvement activities (Fiscella, 2011)….

The Blueprint for Advancing and Sustaining CLAS Policy and Practice acknowledged that comprehensive demographic data may not be routinely collected, and suggested engaging in community partnerships to improve data collection:

> Current surveys and data collection tools may not encompass all demographic groups in a particular area or region. For example, although lesbian, gay, bisexual and transgender related data have been collected on several surveys in the past, there are a number of challenges (HHS, 2012). This can limit the ability to estimate population size and address health needs. Organizations should sensitively and strategically utilize, and develop if necessary, survey instruments that will encompass the various demographic groups in their community. Partnerships, as described in Standard 13, can assist in the identification and development of such instruments.

The Blueprint notes that developing a script about how to ask for data, training admissions and reception staff, using standard data collection instruments, and storing data in a standard electronic format are potential strategies to implement this standard.

[

Umpqua Health Alliance Focus Area 2 System Elements and Data Streams

Umpqua Health Alliance will continue to engage its quality improvement, data analytics, IT, provider network, and member services staff in implementing this strategic goal. All potential sources of member demographic data, including enrollment files, OHA Dashboard data, Children-Complexity data, provider EHRs, local electronic health information exchange (HIE), Health Risk Assessment (HRA) and member engagement and contacts with member services will be accessed and utilized. These data will be used to stratify quality and member experience data by member race, ethnicity, language, and disability status, and analyze themes and trends to identify potential disparities and advance health equity.

Umpqua Health Alliance Focus Area 2 Internal and External Resources Needed

Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 2 Measures for 2020 and Plan for Updates and Revisions

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Umpqua Health Alliance

- By June 2020, Umpqua Health Alliance will develop robust processes, tools and technologies to collect and analyze REAL+D data (Remediation #9, 10)

- By December 2020, Umpqua Health Alliance will identify and implement best practices, tools, and technology for tracking health care and social needs/social determinants data (e.g. risk stratification tools, community resource and referral database, referrals to social services, tracking of social needs met) (Remediation #6)

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 2 will be monitored by the Health Equity Administrator.

Focus Area 3 Culturally and Linguistically Appropriate Services (CLAS)

OHA Expectations
The CCO provides culturally and linguistically appropriate services. The CCO has policies and processes that fully comply with state and federal laws regarding language access and accessibility. The CCO provides free-of-charge certified or qualified oral and sign language interpreters to all consumers, and accessible health and healthcare services for individuals with disabilities following Title III of the ADA.
CCO Contract Exhibit B Part 3 Patient's Rights and Responsibilities, Engagement and Choice (5)
CCO Contract Exhibit B Part 4 Provider and Delivery Systems (2)(g) and (2)(h) and (2)(i) and (2)(j)
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(c)

Umpqua Health Alliance Policies and Procedures

- [see addendum for language assistance policies and procedures]
- Member handbook informing members about language assistance services, services in Spanish, and culturally sensitive health education programs: https://www.umpquahealth.com/wp-content/uploads/2020/02/january2020-uhahandbook-vs-20.6.4.pdf (pages 2, 4-5, 20, 25, 29-30, 34 (Stop Smoking Program in Spanish) 46, 49 (Suicide Prevention Lifeline in Spanish))
- Member handbook, provider directory, advance directive form, and immunization schedule in Spanish available on website: https://www.umpquahealth.com/ohp/

Umpqua Health Alliance Focus Area 3 Strategic Goal(s)

Section-2
Umpqua Health Alliance

By December 2020, Umpqua Health Alliance will implement system and process improvements to ensure culturally and linguistically appropriate health care services for its members, including language assistance services.

Background and Context

CLAS Standard 1 is: “Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs” in order to: “to create a safe and welcoming environment at every point of contact that both fosters appreciation of the diversity of individuals and provides patient- and family-centered care”, “to ensure that all individuals receiving health care and services experience culturally and linguistically appropriate encounters”, “to meet communication needs so that individuals understand the health care and services they are receiving, can participate effectively in their own care, and make informed decisions”, and “to eliminate discrimination and disparities”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> The aim of equitable care and services is to reduce the burden of illness, injury, and disability and to improve the health and functioning of all people in the United States (IOM, 2001). Equity is a key component of quality care (National Quality Forum, 2009). Equitable care and services are influenced by a number of factors, including but not limited to race, education, health literacy, age, sexual orientation, ethnicity, religion, physical or mental disability, language, gender, gender expression, gender identity, income, class, and access to care (California Pan-Ethnic Health Network, 2010; National Partnership for Action to End Health Disparities, 2011).
>
> Understandable care and services rely on a clear exchange of information between those providing care and services and those receiving them. Individuals should be able to fully comprehend how to access care and services, what their treatment options are, and what they need to get and stay well. Ensuring that care and services are understandable is particularly important to those who have limited English proficiency, are deaf or hard of hearing, or may have difficulty comprehending the health care system and its terminology.

CLAS Standard 5 is: “offer communication and language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services” in order to: “to ensure that individuals with limited English proficiency and/or other communication needs have equitable access to health services”, “ to help individuals understand their care and service options and participate in decisions regarding their health and health care”, “to increase individuals’ satisfaction and adherence to care and services”, “to improve patient safety and reduce medical error related to miscommunication”, “to help organizations

comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements". The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> Language assistance services are mechanisms used to facilitate communication with individuals who do not speak English, those who have limited English proficiency, and those who are deaf or hard of hearing…[and] can include in-person interpreters, bilingual staff, or remote interpreting systems such as telephone or video interpreting, as well the translation of written materials or signage, sign language, or braille materials (The Joint Commission, 2010). Language assistance services facilitate the effective and accurate exchange of information between an individual with language and communication needs and his/her provider. By facilitating conversations regarding prevention, symptoms, diagnosis, treatment, and other issues, language assistance improves the quality of services and patient safety….
>
> The primary recipient of language assistance is often the individual receiving care or services; however, other individuals — such as family members or caregivers — may be involved in the provision of support or care to an individual. If family members or caregivers also have limited English proficiency and/or other communication needs, their linguistic needs should also be met to ensure the best outcomes for the individual receiving care. It is important to determine whether the individual's medical decision-maker, health care proxy, or advocate has limited English proficiency, since these individuals may serve as the primary decision-makers regarding the care received by minors, aging parents, and/or individuals with disabilities (National Health Law Program, 2010).

The Blueprint suggests these implementation strategies for offering communication and language assistance:

- Ensure that staff is fully aware of, and trained in, the use of language assistance services, policies, and procedures (HHS OMH, 2005).
- Develop processes for identifying the language(s) an individual speaks (e.g., language identification flash cards or "I speak" cards) and for adding this information to that person's health record (QSource, 2005).
- Use qualified and trained interpreters to facilitate communication (Wilson-Stronks & Galvez, 2007), including ensuring the quality of the language skills of self-reported bilingual staff who use their non-English language skills during patient encounters (Regenstein, Andres, & Wynia, in press).
- Establish contracts with interpreter services for in-person, over-the-phone, and video remote interpreting (HHS OMH, 2005).
- Use cultural brokers when an individual's cultural beliefs impact care communication (Wilson- Stronks & Galvez, 2007).

- Provide resources onsite to facilitate communication for individuals who experience impairment due to a changing medical condition or status (e.g., augmentative and alternative communication resources or auxiliary aids and services) as noted in Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (The Joint Commission, 2010).

CLAS Standard 6 is “inform individuals of the availability of language assistance clearly and in their preferred language, verbally and in writing” in order to: “to inform individuals with limited English proficiency, in their preferred language, that language services are readily available at no cost to them”, “to facilitate access to language services”, “to help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice Blueprint explains:

> Organizations should take the appropriate steps to notify individuals of the availability of language assistance services and that they are available free of cost. Individuals in need of communication and language assistance may not know such services are available to them upon request. Commonly reported barriers to services among individuals who are limited English proficient include the lack of availability of language services or the lack of awareness that such services exist (Barr & Wanat, 2005; Flores, 2006). Thus, organizations should provide notification of the availability of language assistance services at various points of contact and by various means.
>
> Organizations should provide the notification in the individual’s preferred language as determined by a language identification tool (e.g., “I speak” cards). Staff and providers speaking to individuals, whether in person or over the phone, should provide notification of the communication and language assistance available. Notifications should also be provided in print and multimedia materials that are easy to understand and translated into the languages commonly used by the populations in the service area (HHS OMH, 2005).

The Blueprint suggests implementation strategies for communicating or providing notice to individuals about the availability of language services through signs, materials, and multimedia resources, and through cultural mediators and health promotion programs (e.g., community health workers and promotores de salud). Places to provide notice include points of entry and intake, such as registration desks, front desks, waiting rooms, financial screening rooms, pharmacy reception; and areas where clinical work is performed, such as triage and medical exam rooms.

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[ADD any relevant points from community engagement, e.g. identified issues or barriers]

Umpqua Health Alliance Focus Area 3 System Elements and Data Streams
Umpqua Health Alliance will continue to engage its member services and provider network staff in implementing this strategic goal, including monitoring and oversight over contracted providers of language assistance services.

Umpqua Health Alliance Focus Area 3 Internal and External Resources Needed
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 3 Measures for 2020 and Plan for Updates and Revisions

- By December 2020, Umpqua Health Alliance will develop a tracking mechanism to ensure compliance for Focus Area 3

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 3 will be monitored by the Health Equity Administrator.

Focus Area 4 CLAS as an Organizational Framework

OHA Expectations
The CCO, as an organization, has a governance system that promotes health equity through the delivery of Culturally and Linguistically Appropriate Services (CLAS). The CCO, as an organization, fully implements the National CLAS Standards for the provision of culturally and linguistically appropriate services and should allocate the necessary resources for that purpose.
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(d)

Umpqua Health Alliance Policies and Procedures

- [ADD any relevant materials from Board of Directors meetings]
- [ADD any relevant materials from HR, e.g. staff performance evaluation measures]

Umpqua Health Alliance Focus Area 4 Strategic Goal(s)
By December 2024, Umpqua Health Alliance's Board of Directors and Executive Leadership Team[?] will integrate the National CLAS Standards in its governance responsibilities, including oversight, fiscal and human resource allocation, and evaluation.

Background and Context

CLAS Standard 2 is: “advance and sustain governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources ” in order to: “to ensure the provision of appropriate resources and accountability needed to support and sustain initiatives”, “to model an appreciation and respect for diversity, inclusiveness, and all beliefs and practices”, and “to support a model of transparency and communication between the service setting and the populations that it serves”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains that the standard underscores “that CLAS must permeate every aspect of the organization, from the top down and from the bottom up” and that “it is the organization’s leadership that establishes the culture of the organization through its priorities, expectations, and the behavior that it models (Schyve & The Governance Institute, 2009) and through designing service delivery processes and expectations (Rice, 2007).”

The National Quality Forum recommends the following implementation strategies:

- Create and sustain an environment of cultural competency through establishing leadership structures and systems or embedding them into existing structures and systems.
- Identify and develop informed and committed champions of cultural competency throughout the organization in order to focus efforts around providing culturally competent care. Ensure that a commitment to culturally competent care is reflected in the vision, goals, and mission of the organization and couple this with an actionable plan.
- Implement strategies to recruit, retain, and promote at all levels of the organization a diverse leadership that reflects the demographic characteristics of the populations in the service area.
- Ensure that the necessary fiscal and human resources, tools, skills, and knowledge to support and improve culturally competent policies and practices in the organization are available.
- Commit to cultural competency through system-wide approaches that are articulated through written policies, practices, procedures, and programs.
- Actively seek strategies to improve the knowledge and skills that are needed to address cultural competency in the organization.

In addition, CLAS Standard 9 is: “infuse CLAS goals, policies, and management accountability throughout the organization’s planning and operations” in order to: “make CLAS central to the organization’s service, administrative, and supportive functions”, “integrate CLAS throughout the organization (including the mission) and highlight its importance through specific goals”, and “link CLAS to other organizational activities, including policy, procedures, and decision-making related to outcomes accountability”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> Culturally and linguistically appropriate services should be embedded throughout all levels of the organization—from the top down and from the bottom up. The entire health or health care organization affects quality of services and health outcomes of individuals; therefore, the entire organization should fully integrate CLAS- and health equity–related concepts and ideals. Different departments, policies, and roles should coordinate with and complement each other to this end….
>
> In addition, organizations should establish a method (or procedure) of accountability for CLAS activities throughout the organization's hierarchy, from the front desk to the senior executive level. All members of the organization should be trained and supported in making their day-to-day responsibilities culturally and linguistically appropriate and should be evaluated based on criteria relevant to CLAS and their role(s) within the organization (see Standard 4).

The Blueprint for Advancing and Sustaining CLAS Policy and Practice lists the following as potential implementation strategies:

- Engage the support of governance and leadership, and encourage the allocation of resources to support the development, implementation, and maintenance of culturally and linguistically appropriate services.
- Encourage governance and leadership to establish education and training requirements relating to culturally and linguistically appropriate services for all individuals in the organization, including themselves.
- Identify champions within and outside the organization to advocate for CLAS, to emphasize the business case and rationale for CLAS, and encourage full-scale implementation.
- Hold organizational retreats to identify goals, objectives, and timelines to provide culturally and linguistically appropriate services.
- Establish accountability mechanisms throughout the organization, including staff evaluations, individuals' satisfaction measures, and quality improvement measures (QSource, 2005).

<u>Umpqua Health Alliance Focus Area 4 System Elements and Data Streams</u>
Umpqua Health Alliance Board of Directors and executive leadership team are responsible for implementing this strategic goal.

<u>Umpqua Health Alliance Focus Area 4 Internal and External Resources Needed</u>
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

<u>Umpqua Health Alliance Focus Area 4 Measures for 2020 and Plan for Updates and Revisions</u>

- By April 2020, Umpqua Health Alliance will review, assess, and make appropriate changes to organizational structure including the designation

of a Health Equity Administrator and the establishment of a health equity committee [Co-Chaired by a Board Member, with Tribal Government and CAC representation] to work with leadership and all functional areas of UHA to develop a health equity plan that will be applied across the organization, both internally and externally. (Remediation #8)

- By December 2020, Umpqua Health Alliance will identify, assess, and address barriers to community engagement; and will develop a means to share the community engagement plan and annual updates publicly. (Remediation #11 and 14)

- By December 2020, Umpqua Health Alliance will develop a clear plan for varying levels of meaningful community engagement from UHA members and non-members that addresses a broad set of UHA decisions, activities and deliverables that are not limited to the CHA/CHP process. (Remediation #11 and 13)

- By December 2020, Umpqua Health Alliance will strengthen outreach strategies beyond CCO staff and CAC dissemination, to ensure funding opportunities are disseminated broadly and reach new potential partners, including culturally specific organizations and community partners that serve marginalized populations, (Remediation #17)

- By December 2020, Umpqua Health Alliance will establish and/or detail set criteria for project evaluation in order to ensure fairness and reduce bias; will establish criteria using a public, transparent process, such as through the CAC; and will clarify how organizations seeking funding can identify any conflicts of interest. (Remediation #17)

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 4 will be monitored by the Co-Chairs of the Health Equity Committee and the Health Equity Administrator, and will be reported to the Executive Team and the UHA Board of Directors.

Focus Area 5 Workforce

OHA Expectations
The CCO's recruitment processes focus on diversity, equity, and inclusion recruitment and retention strategies. CCO develops organization wide strategies to recruit, promote, and support a culturally and linguistically diverse workforce, from the front desk staff to senior leadership to external contractors and partners.
CCO Contract Exhibit B Part 4 Provider and Delivery Systems (4)
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(e)

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CCO Contract Exhibit K Part 11 Traditional Health Workers

Umpqua Health Alliance Policies and Procedures

- [see addendum for workforce diversity plan]

Umpqua Health Alliance Focus Area 5 Strategic Goal(s)

By December 2024, Umpqua Health Alliance will implement strategies to recruit, promote, and support a culturally and linguistically diverse workforce.

Background and Context

CLAS Standard 3 is: "recruit, promote, and support a diverse governance, leadership, and workforce that are responsive to the population in the service area" in order to: "create an environment in which culturally diverse individuals feel welcomed and valued", "promote trust and engagement with the communities and populations served", "infuse multicultural perspectives into planning, design, and implementation of CLAS", "ensure diverse viewpoints are represented in governance decisions", and "increase knowledge and experience related to culture and language among staff". The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> Evidence indicates that an increase in racial and ethnic diversity among health professionals is associated with increased access to care for racial and ethnic minority patients, greater patient choice, more patient satisfaction and patient engagement, improved communication, and improved educational experiences for health students (Cooper & Powe, 2004; IOM, 2004). Being responsive to the community is important at all levels of the organization, including in the provision of care and services, strategic planning, evaluation, and decision-making (Cooper & Powe, 2004)….
>
> Responsive care should also apply across various contractual relationships. Many health care organizations use networks or affiliated providers to deliver services to their constituents. It is important that staff diversity encompasses all individuals involved in health care delivery, whatever their contractual or subcontractual relationship with the organization.

The Blueprint suggests the following implementation strategies:

- Advertise job opportunities in targeted foreign language and minority health professional associations' job boards, publications, and other media (e.g., social media networks, professional organizations' email Listservs, etc.), and post information in multiple languages (QSource, 2005).
- Develop relationships with local schools, training programs, and faith-based organizations to expand recruitment base (QSource, 2005).
- Recruit at minority health fairs (QSource, 2005).

- Collaborate with businesses, public school systems, and other stakeholders to build potential workforce capacities and recruit diverse staff. In particular, linkages between academic and service settings can help identify potential recruits already in the educational “pipeline” and provide them with additional academic support and resources necessary to meet job requirements (The Sullivan Commission on Diversity in the Healthcare Workforce, 2004).
- Assess the language and communication proficiency of staff to determine fluency and appropriateness for serving as interpreters.

The U.S. Department of Health and Human Services Office of Minority Health recommends the following implementation strategies:

- Promote mentoring opportunities.
- Conduct regular, explicit assessments of hiring and retention data, current workforce demographics, promotion demographics, and community demographics.
- Monitor work assignments and hire sufficient personnel to ensure a manageable and appropriate workload for bilingual/bicultural staff members.
- Use nonclinical support staff in cultural broker positions only after providing sufficient training and recognition (e.g., compensation, job title, or description).
- Promote diverse staff members into administrative or managerial positions where their cultural and linguistic capabilities can make unique contributions to planning, policy, and decision-making.
- Foster an environment in which differences are respected and that is responsive to the challenges a culturally and linguistically diverse staff brings into the workplace.

<u>Umpqua Health Alliance Focus Area 5 System Elements and Data Streams</u>
Umpqua Health Alliance will continue to engage its human resources and provider network staff in implementing this strategic goal.

<u>Umpqua Health Alliance Focus Area 5 Internal and External Resources Needed</u>
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

<u>Umpqua Health Alliance Focus Area 5 Measures for 2020 and Plan for Updates and Revisions</u>

- By December 2020, Umpqua Health Alliance will develop and implement a workforce diversity and inclusion plan (Remediation #7)

- By December 2020, Umpqua Health Alliance will UHA will work with existing and new partners, including community stakeholders, to design a

THW Integration and Utilization Plan. The plan will drive efforts to publicize currently available services; increase its recruitment and retention of THWs in its operations, including through payment strategies; and include strategies to expand THW services beyond behavioral health. (Remediation #12)

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 5 will be monitored by the Health Equity Administrator and Human Resources Manager.

Focus Area 6 Organizational Training and Education

OHA Expectations
The CCO develops an Organizational and Provider Network Cultural Responsiveness, Implicit Bias Training and Education Plan that includes its governing board, leadership, Community Advisory Council (CAC) and the provider network.[2]
CCO Contract Exhibit B Part 3 Patient's Rights and Responsibilities, Engagement and Choice (1)(c)
CCO Contract Exhibit B Part 4 Provider and Delivery Systems (4)(b)(5)
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(f) and (d)

Umpqua Health Alliance Policies and Procedures
- [ADD staff orientation and training content related to cultural responsiveness, implicit bias, and CLAS]
- [ADD Board of Directors education and training plans related to cultural responsiveness, implicit bias, and CLAS]
- [ADD Community Advisory Council education and training plans related to cultural responsiveness, implicit bias, and CLAS]
- [ADD provider contract education and training requirements related to cultural responsiveness, implicit bias, and CLAS]
- [ADD provider education and training plan related to cultural responsiveness, implicit bias, and CLAS]

Umpqua Health Alliance Focus Area 6 Strategic Goal(s)
By December 2024, Umpqua Health Alliance will integrate cultural responsiveness, implicit bias, and CLAS into its staff, Board of Directors, Community Advisory Council, and provider network education and training activities.

Background and Context

[2] This focus area has special reporting requirements outlined on a separate guidance document.

CLAS Standard 4 is: “Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis” in order to: “prepare and support a workforce that demonstrates the attitudes, knowledge, and skills necessary to work effectively with diverse populations”, “increase the capacity of staff to provide services that are culturally and linguistically appropriate”, “assess the progress of staff in developing cultural, linguistic, and health literacy competency”, and “foster an individual’s right to respect and nondiscrimination by developing and implementing education and training programs that address the impact of culture on health and health care”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> In order for CLAS to be fully implemented, education and training for professionals working in health and human services must be ongoing. Cultural and linguistic competency concepts — including effective communication and patient-, family-, and community-based practices — should be incorporated not only into all formal educational curricula but also into new and existing staff training and curricula.
>
> Ongoing education and staff training ensures that governance, leadership, and the workforce are equipped with adequate knowledge, tools, and skills to appropriately manage cross-cultural encounters with individuals (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003)….
>
> Education and training should be based on sound educational principles (e.g., adult learning), including pre- and post-training assessments, and be conducted by appropriately qualified individuals. For training, a knowledge-based, skill-based, or attitude-based approach should be adopted, based upon the needs and weaknesses of the organization, with the goal of ensuring the success of the training (Rose, 2011).

The Blueprint recommends the following potential implementation strategies:

- Engage staff in dialogues about meeting the needs of diverse populations (Wilson-Stronks & Galvez, 2007).
- Provide ongoing in-service training on ways to meet the unique needs of the population, including regular in-services on how and when to access language services for individuals with limited English proficiency (Wilson-Stronks & Galvez, 2007).
- Take advantage of internal and external resources available to educate governance, leadership, and workforce on cultural beliefs they may encounter (Wilson-Stronks & Galvez, 2007).
- Allocate resources to train current staff in cultural competency or as medical interpreters if they speak a second language, have completed language assessments, and show an interest in interpretation (QSource, 2005).

- Incorporate cultural competency and CLAS into staff evaluations (QSource, 2005).
- Provide opportunities for CLAS training that include regular in-services, brown-bag lunch series, orientation materials for new staff, and annual update meetings (QSource, 2005).
- Encourage staff to volunteer in the community and to learn about community members and other cultures (QSource, 2005), and work with community leaders and cultural brokers to create opportunities for such interactions.
- Evaluate education and training (see Standard 10).
- Take advantage of live and Web-based health disparities and cultural competency continuing education programs for clinicians and practitioners (Like, 2011).

Umpqua Health Alliance Focus Area 6 System Elements and Data Streams
Umpqua Health Alliance's human resources staff, provider network staff, and Health Equity Committee Chairs [including a Board member as a Co-Chair with the HEA, and a CAC member] and the Community Advisory Council will develop, implement, and continuously evaluate these education and training plans and activities. Participant feedback will be collected and used for continuous improvement.

Umpqua Health Alliance Focus Area 6 Internal and External Resources Needed
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 6 Measures for 2020 and Plan for Updates and Revisions

- By December 2020, Umpqua Health Alliance will deploy the CLAS and Implicit Bias trainings for all Employees

- By December 2020, Umpqua Health Alliance will deploy the CLAS and Implicit Bias trainings for Board and CAC members.

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 6 will be monitored by the Health Equity Administrator, Human Resources Manager.

Focus Area 7 Language Access Reporting Mechanisms

OHA Expectations

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The CCO invests resources, develops processes and implements tracking mechanisms that ensure CCO and provider network provides readily available, high-quality, language assistance services.
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(g)
OAR 410-141-3515

Umpqua Health Alliance Policies and Procedures

- [see addendum for language assistance policies and procedures]
- Member handbook informing members about language assistance services, services in Spanish, and culturally sensitive health education programs: https://www.umpquahealth.com/wp-content/uploads/2020/02/january2020-uhahandbook-vs-20.6.4.pdf (pages 2, 4-5, 20, 25, 29-30, 34 (Stop Smoking Program in Spanish) 46, 49 (Suicide Prevention Lifeline in Spanish))
- Member handbook, provider directory, advance directive form, and immunization schedule in Spanish available on website: https://www.umpquahealth.com/ohp/

Umpqua Health Alliance Focus Area 7 Strategic Goal(s)
By December 2024, Umpqua Health Alliance will implement system and process improvements that ensure that the CCO and its provider network provides readily available, high-quality, language assistance services.

Background and Context
CLAS Standard 7 is: “ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided” in order to: “provide accurate and effective communication between individuals and providers”, “reduce misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and patient safety issues due to reliance on staff or individuals that lack interpreter training”, “empower individuals to negotiate and advocate, on their own behalf, for important services via effective and accurate communication with health and health care staff”, and “help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> Language ability alone does not qualify an individual to provide language assistance, using ad hoc interpreters or untrained individuals and/or minors as interpreters may appear to be a convenient or reasonable option for the individual and provider alike. For service providers, using an ad hoc interpreter may appear to be advantageous because there may be little or no upfront financial cost associated with using untrained individuals and/or minors, and there may be little to no interruption in service delivery, since the untrained individual is likely readily available. However, the use

of unqualified interpreters can have dire consequences. Grave errors have occurred when untrained individuals have been used as interpreters, including misdiagnoses and significant medical errors (Flores, 2005; Flores et al., 2003), which may place the individual at increased risk of significant injury or death.

Untrained family, friends, minors, and staff often do not possess the necessary skills to provide meaningful language services. Moreover, given their relationship to the patient, the use of friends, family members, and minors may compromise the autonomy and confidentiality of the communication (AMA, 2006; Diamond & Jacobs, 2010).

The use of clinical and nonclinical staff who speak a non-English language but who are untrained in medical interpretation can pose potential safety risks (Regenstein et al., in press). Research has shown that when clinicians speak a non-English language, or when untrained bilingual staff is available, an important set of potential barriers can arise and hinder the effective and appropriate use of trained interpreters (Maul, Regenstein, Andres, Wright, & Wynia, 2012).

The Blueprint suggest the following potential implementation strategies:

- Assess the individual's language ability. There exist many options for testing an individual's ability to communicate in a foreign language.
- Assess the individual's ability to provide language assistance the National Council on Interpreting in Health Care has issued standards of practice that define expectations of performance and outcomes for health care interpreters (2005).
- Employ a "multifaceted model" of language assistance. Organizations may provide language assistance according to a variety of models, including bilingual staff or dedicated language assistance (e.g., a contract interpreter or video remote interpreting). A combination of models, or a multifaceted model, offers the organization a "comprehensive and flexible system [for] facilitating communication" (National Council on Interpreting in Health Care, 2002, p. 4). Under a multifaceted model, for example, telephonic interpreting will supplement the language assistance provided by bilingual staff to ensure that at all times, language assistance is being provided by competent individuals.

<u>Umpqua Health Alliance Focus Area 7 System Elements and Data Streams</u>
Umpqua Health Alliance will continue to engage its member services and provider network staff in implementing this strategic goal. Quantitative and qualitative data will be collected and used to monitor the quality and timely availability of language assistance services.

<u>Umpqua Health Alliance Focus Area 7 Internal and External Resources Needed</u>

Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 7 Measures for 2020 and Plan for Updates and Revisions

- By December 2020, Umpqua Health Alliance will create a Language Access plan

- By December 2020, Umpqua Health Alliance will create a measurement process to monitor the quality of translational services.

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 7 will be monitored by the Health Equity Administrator.

Focus Area 8 Member Education and Accessibility

OHA Expectations
The CCO develops member educational and other materials (print, multimedia, etc.) that are in plain language and that are available in alternative formats; utilizes IT and other tools and resources for consumers who are blind or deaf, or otherwise disables (e.g. literacy programs).
CCO Contract Exhibit B Part 3 Patient's Rights and Responsibilities, Engagement and Choice
CCO Contract Exhibit K Part 10 Health Equity Plan (c)(2)(h)

Umpqua Health Alliance Policies and Procedures

- Member handbook defining "words to know" in plain language: https://www.umpquahealth.com/wp-content/uploads/2020/02/january2020-uhahandbook-vs-20.6.4.pdf (pages 8-12)
- Member handbook explaining information about in alternative formats: https://www.umpquahealth.com/wp-content/uploads/2020/02/january2020-uhahandbook-vs-20.6.4.pdf (pages 2, 4-5, 20)
- [see addendum for policies and procedures on plain language and health literacy]

Umpqua Health Alliance Focus Area 8 Strategic Goal(s)
By December 2024, Umpqua Health Alliance will implement system and process improvements to ensure that all member educational materials and communications are in plain language and that are available in alternative formats.

Section-2
Umpqua Health Alliance

Background and Context

CLAS Standard 8 is: “Provide easy-to-understand materials and signage in the languages commonly used by the populations in the service area” in order to: “ensure that readers of other languages and individuals with various health literacy levels are able to access care and services”, “provide access to health-related information and facilitate comprehension of, and adherence to, instructions and health plan requirements”, “enable all individuals to make informed decisions regarding their health and their care and services options”, “offer an effective way to communicate with large numbers of people and supplement information provided orally by staff members”, and “help organizations comply with requirements such as Title VI of the Civil Rights Act of 1964; the Americans with Disabilities Act of 1990; and other relevant federal, state, and local requirements”. The Blueprint for Advancing and Sustaining CLAS Policy and Practice explains:

> …many health materials are written at a level too high for the average consumer to understand (Rudd, Moeykens, & Colton, 2000). The challenge to understand health materials is even greater for the one-third of adults with limited health literacy (HHS ODPHP, 2010). Minority populations are disproportionately represented among those with basic or below basic health literacy skills (Kutner et al., 2006), and the failure to address health literacy may exacerbate disparities (Koh et al., 2012). Health literate organizations design and distribute print, audiovisual, and social media content that is easy to understand and act on (Brach et al., 2012). Such materials use appropriate graphics, employ user- friendly design, focus on actionable information, and refrain from using jargon. Health materials should be used effectively as part of an educational strategy rather than becoming a substitute for spoken instruction (AHRQ, 2010). Similarly, clear signage does not obviate the need for other navigational assistance.

The Blueprint provide the following potential implementation strategies:

- Issue plain language guidance and create documents that demonstrate best practices in clear communication and information design (HHS ODPHP, 2010).
- Create forms that are easy to fill out, and offer assistance in completing forms (AHRQ, 2010).
- Consult local librarians to help build an appropriate collection of health materials (HHS ODPHP, 2010).
- Train staff to develop and identify easy-to-understand materials, and establish processes for periodically re-evaluating and updating materials (AHRQ, 2010).
- Develop materials in alternative formats for individuals with communication needs, including those with sensory, developmental, and/or cognitive impairments as noted in Advancing Effective

Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals (The Joint Commission, 2010).

- Test materials with target audiences. For example, focus group discussions with members of the target population can identify content in the material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples, and assess whether graphics reflect the diversity of the target community. Organizations should consider providing financial compensation or in-kind services to community members who help translate and review materials (HHS OMH, 2001).

Umpqua Health Alliance Focus Area 8 System Elements and Data Streams
Umpqua Health Alliance will continue to engage its member services and communications staff in implementing this strategic goal. The Community Advisory Council also will review member educational materials and communications to provide feedback about health literacy issues.

Umpqua Health Alliance Focus Area 8 Internal and External Resources Needed
Umpqua Health Alliance has the internal staff and operational resources to implement these activities.

Umpqua Health Alliance Focus Area 8 Measures for 2020 and Plan for Updates and Revisions

- By December 2020, Umpqua Health Alliance will establish a Member Engagement and Health Equity Committee (MEHE) [with external stakeholder participation].

- By December 2020, Umpqua Health Alliance will share the Member specific resources implementation process with the MEHE Committee

- By December 2020, Umpqua Health Alliance will evaluate its progress on the above measures and update and revise these measures for 2021 as necessary.

Umpqua Health Alliance Responsible Staff
Progress on Umpqua Health Alliance's activities related to Focus Area 8 will be monitored by the Health Equity Administrator and Director Member Services.

SECTION-3

The Following Policies and Plans will be submitted to OHA:

Policies:

1. Health Information System Management
2. Encounter Data Submission and Validation
3. Grievances
4. Appeals & Hearings
5. Adverse Benefits Determinations
6. Data Backup and Storage
7. Data and Application Critical Application
8. Outsourced Data and Processing
9. Member Assignment and Reassignment
10. Member Rights
11. Written Notice to Members
12. Request for Interpreters or Alternative Format
13. Member Handbook
14. Member Enrollment and Disenrollment
15. Data Validation Process
16. Member Engagement in Quality Programs

Plans:

1. Umpqua Health Alliance Workforce Diversity and Inclusion plan
2. THW Integration and Utilization plan
3. Cultural Responsiveness and Implicit Bias Training and Education Plan; curriculum

UMPQUA HEALTH

Umpqua Health Alliance Organizational Cultural Responsiveness and Implicit Bias Training and Education Plan

June 2020

TABLE OF CONTENTS:

Umpqua Health Alliance Organizational Cultural Responsiveness and Implicit Bias Training and Education Plan

VISION OF THE PLAN:

Umpqua Health Alliance (UHA) shall provide and incorporate cultural responsiveness and implicit bias continuing education and trainings into its existing organization-wide training plans and programs. UHA shall also adopt the definition of Cultural Competence and utilize such definition to guide its development of cultural responsiveness materials and topics in its Cultural Competence Continuing Education training activities into its training plans for Health Care Professionals. All employee training offerings include the following fundamental areas:

- Implicit bias/addressing structural barriers and systemic structures of oppression;
- Language access (including use of plain language) and use of Health Care Interpreters, including without limitation, the use of Certified or Qualified Healthcare and American Sign Language interpreters;
- The use of CLAS standards in the provision of services;
- Adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma;
- Uses of REAL+D data to advance Health Equity;
- Universal access and accessibility in addition to compliance with the ADA, and;
- Health literacy.

UHA will provide and require that all employees, including directors and executives, to participate in all such trainings and shall incorporate fundamental areas of cultural responsiveness and implicit bias trainings relating to the use of healthcare interpreters in all New Employee Orientations and annual trainings.

CULTURAL COMPENTENCE:

Domain 1: Culturally competent practice requires self-awareness and self-assessment of providers' beliefs, attitudes, emotions and values.

- Training opportunity teaches about cultural factors that may influence provider and patient's behaviors;
- Training opportunity helps to foster a non-judgmental and respectful environment during health encounters between provider and patient;
- Training opportunity teaches relationship between cultural competence and ethics;
- Training opportunity explores concepts of power, privilege and oppression across personal identities and the intersections among these identities (e.g. racial, ethnic, culturally-based, LGBTQ, people with disabilities, limited English, etc.)

Domain II: Culturally competent practice requires the acquisition of knowledge by providers.

- Training opportunity demonstrates understanding of cultural competence as a developmental, life long, participatory process, not an endpoint;
- Training opportunity provides a broad and inclusive definition of diversity, even if it focuses on a specific population;

- Training opportunity demonstrates knowledge of legal, regulatory (i.e. patient rights and responsibilities, risks to practice-civil rights act, ADA, CLAS, Joint Commission requirements, etc.) and accreditation issues of diversity and linguistic issues and providers' professional standards regarding cultural competence;
- Training opportunity demonstrates knowledge of health disparities and social determinants of health;
- Training opportunity demonstrates knowledge of culturally-based information and related resources specific to Oregon.

Domain III: Culturally competent practice requires the acquisition of skills by providers.

- Training opportunity demonstrates how to collaborate with patients and/or stakeholders in making health care decisions;
- Training opportunity demonstrates how to develop and/or utilize communications tools/multiple patient education formats (including translated, audio and visual materials) and patient assessment strategies (e.g. patient-and family-centered communication, patient's perception of his/her health, patient preferences, etc.)
- Training opportunity demonstrates how to collect and utilize data to inform clinical practice related to health equity (including recognition of institutional cultural issues);
- Training opportunity demonstrates how to collaborate effectively with community resources, stakeholders, traditional health workers (THWs), qualified/certified health care interpreters (HCIs), providers and other types of healers.

Domain IV: Culturally competent training requires specific educations approaches for acquisition of knowledge and skills.

- Training opportunity is delivered through facilitated learning processes (e.g. interactive training involving case review; homework; discussion group/blog; interactive test with trainer/facilitator; post-training to demonstrate what was learned, etc.);
- Training opportunity uses a variety collaborative, inclusive and accessible teaching methodologies consistent with adult learning principles (self-directed, goal oriented activities based on participant experiences in order to gain new forms of knowledge, skills, attitudes or values);
- Training opportunity is evaluated to assess impact on participants and efficacy of trainers, with clear description of criteria for participant completion;
- Training opportunity incorporates the principles of privilege, power, oppression, bias, and the guiding principles of cultural competency.

IMPLEMENTATION:

The training and education plan will begin implementation in 2020 and shall follow a timeline for providing all required education and training activities and develop goals and objectives for employees. UHA's Human Resources department will oversee the implementation of the plan and ensure completion by all employees, including directors and executives, the Umpqua Health Community Advisory Council (CAC) and Umpqua

Health Alliance Board members annually. The plan will also include evidence of UHA's adoption of Cultural Competence criteria and core competencies.

UHA will also develop and implement review processes of the training and education plan that will allow UHA to monitor and measure both the qualitative and quantitative progress, impact and effectiveness of the training and education being provided. Additionally, UHA will prepare an Annual Training and Education Report to capture all training activities that were provided to employees, including reporting of training subjects, content outlines and materials, assessment of goals and objectives, target audiences, delivery system, evaluations, training dates and hours, training attendance and trainer qualifications.

EMPLOYEE GOALS AND OBJECTIVES:

Goal 1: Employees will practice self-awareness and self-assessment of beliefs, attitudes, emotions and values in order to foster a non-judgmental and respectful environment during health encounters.

Goal 2: Employees will demonstrate understanding of cultural competence as a developmental, lifelong participatory process, not an endpoint.

Goal 3: Employees will collaborate effectively with community resources, stakeholders, traditional health workers (THWs), qualified/certified health care interpreters (HCIs), providers and other types of healers.

Goal 4: Employees will understand the principles of privilege, power, oppression, bias, and the guiding principles of cultural competency.

ADOPTION OF CRITERIA AND CORE COMPETENCIES:

Strategy 1: UHA will add the definition of Cultural Competence to the Umpqua Health Employee Handbook. The Employee Handbook is provided to all employees upon hire. Employees are asked to review the handbook and attest that they are given a copy.

Strategy 2: UHA will add cultural competency criteria to its performance review system. Umpqua Health completes quarterly performance reviews for all employees.

EDUCATION AND TRAINING ACTIVITIES TIMELINE:

February 2020

- New Employee Orientation

May 2020

- New Employee Orientation (postponed to August due to COVID-19)

July 2020

- Cultural Responsiveness/Implicit Bias Training (online)

- Recognizing & Overcoming Unconscious Bias (Clinical and Non-Clinical)
- ResCUE Model for Cross Cultural Communication (Clinical and Non-Clinical)

August 2020

- New Employee Orientation
- Interactive Department Workshops to debrief Cultural Responsiveness/Implicit Bias trainings

September 2020

- Compliance Trainings (online)
  - Fraud, Waste, & Abuse
  - Compliance Plan/Program Overview
  - Code of Conduct Review
  - Conflict of Interest Review/Disclosure
  - Bloodborne Pathogens: Federal & Oregon
  - Workplace Harassment: Federal & Oregon

November 2020

- New Employee Orientation
- Compliance Trainings (online)
  - HIPAA – Privacy, Security & Retention of Records; Breach Notification
  - Workplace Security
  - Remote Worker Security

December 2020

- Foundations of Trauma Informed Care
- Behavioral Health Integration
- Motivational Interviewing
- Recovery Principles
- Compliance: Excluded Provider Requirements
- Compliance: Provider Screening, Enrollment Requirements
- Child & Adolescent Needs & Strengths Comprehensive Screening Certification

ANNUAL EDUCATION AND TRAINING REPORT:

New Employee Orientation

Target Audience: Employees that are new to the organization.

Dates/Hours: Four (4) times per year, to take place during the second month of each quarter. Orientation lasts approximately eight (8) hours.

Umpqua Health Alliance Organizational Cultural Responsiveness and Implicit Bias Training and Education Plan

Objective: To help new employees feel welcomed, integrated into the organization, and performing their new job duties as successfully as possible. Additionally, UH endeavors to incorporate the fundamentals of cultural responsiveness and implicit bias into New Employee Orientation.

Training Subjects:

- Umpqua Health Organizational Structure/Culture
- Employee Handbook Overview
- Sexual Harassment training
- Cultural Responsiveness/Implicit Bias training
- Umpqua Health Benefits Overview
- 401K Presentation
- Compliance Program Presentation
- Safety Program Presentation

Trainer Qualifications: Content is prepared and presented by the Human Resources team, which includes 10+ years Human Resources and CCO experience.

Delivery Systems: Oral presentation, PowerPoint, group activities.

Attendance: Attendance is planned for prior to and taken at Orientation. Participation is mandatory.

Evaluation: Feedback survey provided at the end of Orientation.

Cultural Responsiveness/Implicit Bias Training
Target Audience: All Umpqua Health employees, leadership, board members, and CAC members.

Dates/Hours: Approximately 8-10 hours per year.

Objective: To provide all employees with initial and continuing education about the fundamental areas of Cultural Competence and Implicit Bias.

Training Subjects:

- Implicit bias/addressing structural barriers and systemic structures of oppression,
- Language access (including the use of plain language) and use of Health Care Interpreters, including without limitation, the use of Certified or Qualified Healthcare and American Sign Language interpreters.
- The use of CLAS Standards in the provision of services.
- Adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma.
- Uses of REAL+D data to advance Health Equity.
- Universal access and accessibility in addition to compliance with the ADA, and

- Health literacy.

Trainer Qualifications: Content is prepared and presented by the Human Resources team, which includes 10+ years Human Resources and CCO experience.

Delivery Systems: Online training, in-person training, interactive workgroups and activities.

Attendance: Participation is mandatory and completion will be confirmed and tracked by Human Resources.

Evaluation: Feedback will be gathered via survey.

Foundations of Trauma Informed Care
Target Audience:

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Behavioral Health Integration
Target Audience:

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Motivational Interviewing
Target Audience:

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Recovery Principles
Target Audience:

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Child & Adolescent Needs & Strengths Comprehensive Screening Certification
Target Audience:

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Compliance: Excluded Provider Requirements
Target Audience: Credentialing staff and subcontractors only.

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

Compliance: Provider Screening, Enrollment Requirements
Target Audience: Credentialing staff and subcontractors only.

Dates/Hours:

Objective:

Training Subjects:

-

Trainer Qualifications:

Delivery Systems:

Attendance:

Evaluation:

#	Title	Regulatory Body
1	Adverse Benefit Determinations	OHA- CCO Contract
2	Appeals & Hearings	OHA- CCO Contract
3	Best Practices, Quality of Care, Screenings, etc.	OHA- CCO Contract
4	Bloodborne Pathogens: Federal & Oregon	OSHA Oregon OSHA
5	Bloodborne Pathogens: Oregon	Oregon OSHA
6	CCO Contract Standards and Requirements	CMS/OHA
7	Child & Adolescent Needs & Strengths Comprehensive Screening Certification	OHA- CCO Contract
8	Complaince, FWA	OHA- CCO Contract
9	Compliance: FWA: Medicare/Medicaid Fraud, Waste and Abuse	CMS
10	Complaince: Guidance for Health Care Boards (video)	OIG
11	Compliance Plan/Program	OHA- CCO Contract

12	Compliance Program, General: Plans	OIG
13	Compliance: Code of Conduct	OHA- CCO Contract
14	Compliance: Conflict of Interest	Umpqua Health OHA - CCO Contract
15	Compliance: Excluded Provider Requirements	OHA- CCO Contract
16	Compliance: Fiduciary Responsibility	Umpqua Health
17	Compliance: Practical Guidance for Health Care Boards on Compliance Oversight	OIG
18	Compliance: Provider Screening, Enrollment Requirements	OHA- CCO Contract
19	Coordinated Care Approach in Community	OHA- CCO Contract
20	Cultural Responsiveness & Implicit Bias	OHA- CCO Contract
21	Culturally and Linguistically Appropriateness	OHA- CCO Contract
22	FBDE Members Edu on Benefits - Affiliated MA and/or DSPN Plans	OHA- CCO Contract
23	Foundations of Trauma Informed Care	OHA- CCO Contract
24	Grievances	OHA- CCO Contract
25	Health Equity - REAL+D Awareness & Tools	OHA- CCO Contract
26	HIPAA - Compliance	OHA- CCO Contract

27	HIPAA - Privacy, Security, & Retention of Records; Breach Notification	OHA- CCO Contract
28	HIPAA Privacy/Security	HHS
29	ICC Services (screenings/services & other supports)	OHA- CCO Contract
30	Integrated & Coordinated Services Plan, Member Education	OHA- CCO Contract
31	Integration	OHA- CCO Contract
32	Member Education - Prevention & Early Intervention of illness and disease	OHA- CCO Contract
33	Member Education - Tobacco Cessation	OHA- CCO Contract
34	Member Rights, Member Education	OHA- CCO Contract
35	Member Rights, Provider Network	OHA- CCO Contract
36	Motivational Interviewing	OHA- CCO Contract
37	NEMT Adverse Weather Plan	OHA- CCO Contract
38	NEMT Call Center Training	OHA- CCO Contract
39	NEMT Cultural / Driving Training	OHA- CCO Contract
40	Recovery Principles	OHA- CCO Contract
41	THW Services, Member Education	OHA- CCO Contract
42	THW Services, Provider Network Education	OHA- CCO Contract
43	TPLR P&P Guidebook, Member Education	OHA- CCO Contract
44	TPLR P&P Guidebook, Provider Education	OHA- CCO Contract
45	Trauma Informed Care	OHA- CCO Contract
46	Workplace Harassment: Oregon	Oregon Bureau of Labor and Industries
47	Workplace Harassment: Federal	EEOC

48	Workplace Safety, General : Federal	OSHA
49	Workplace Safety, General: Oregon	Oregon OSHA
50	Wraparound Training	OHA- CCO Contract

Addendum

CORPORATE POLICY & PROCEDURE

	Policy Name: Health Information System Management
Department: Claims Administration	Policy Number: CA1
Version: 2	Creation Date: 5/11/2018
Revised Date: 7/28/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Michael von Arx, Chief Operating Officer Date: 7/29/2019

POLICY STATEMENT

Umpqua Health Alliance (UHA) must comply with the Oregon Health Authority (OHA) Coordinated Care Organization (CCO) Contract (Exhibit J) for maintaining a health information system pertaining to members, in accordance with the requirements of 42 CFR § 438.242 and section 1903(r)(1)(F) of the Patient Protection and Affordable Care Act (PPACA). Failure to comply with these regulations may result in such consequences as monetary penalties, imprisonment, and/or loss of contract.

PURPOSE

This policy serves to demonstrate how UHA will comply with health information system requirements and regulations to meet contractual obligations with the OHA.

RESPONSIBILITY

Claims Administration

DEFINITIONS

Coordinated Care Organization (CCO): A coordinated care organization is a network of all types of health care providers (physical, behavioral and dental health) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).

Encounter Data: Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form.

	Policy Name: Health Information System Management
Department: Claims Administration	Policy Number: CA1
Version: 2	Creation Date: 5/11/2018
Revised Date: 7/28/19	Review Date:

Health Information System (HIS): A combination of vital and health statistical data from multiple sources, used to derive information about the health needs, health resources, use of health services, and outcomes of use by the people in a defined region or jurisdiction.

Managed Care Organization: Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers.
Protected Health Information (PHI): Any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity (or a business associate of a covered entity), and can be linked to a specific individual.

Validation: The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.

PROCEDURES

General Requirements

1. UHA or its subcontractors will maintain a health information system that collects, analyzes, integrates, and reports data that can provide information on areas including, but not limited to:
    a. Names and phone numbers of member's primary care physician (PCP) or clinic;
    b. Client process monitoring systems forms data using the Measure and Tracking System (MOTS) data;
    c. Copies of completed request for long term psychiatric care (LTPC) determination forms;
    d. Evidence that the member has been informed of rights and responsibilities;
    e. Grievances;
    f. Appeals;
    g. Contested case hearing records;
    h. Utilization of services;
    i. Claims and encounters;
    j. Disenrollment for loss of Medicaid eligibility;
    k. Covered services provided to members, through encounter data system or other documentation system;
    l. Member demographics such that such information collected includes, at a minimum, those characteristics required to be collected under Exhibit K, Section 6 of the CCO Contract;

m. Provider characteristics required to be collected under Exhibit G of the CCO Contract;
n. Member enrollment;
o. Services provided to members for pharmacy services; and
p. All data required to be reported in connection with encounter data reporting.

Basic Elements of a Health Information System

1. As required by the OHA, UHA will:
    a. Ensure that the health information system complies with the Section 6504(a) of the Affordable Care Act by certifying that claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the OHA to meet the requirements of Section 1903(r)(1)(F) of the Social Security Act.
        i. In accordance with 42 CFR §§ 433.116(e)-(f) and 455.20(a), for utilizing mechanized systems, UHA will audit services received by members to confirm that billed services were provided in accordance with its CO28 – Verification of Services policy.
    b. Make sure that the system collects data on enrollee and provider characteristics as specified by OHA and on all services furnished to enrollees through an encounter data system or other methods in alignment with the CCO Contract requirements. This will include but not be limited to the following:
        i. Race;
        ii. Ethnicity;
        iii. Preferred language;
        iv. Names and phone numbers of the member's PCP or clinic; and
        v. Attestation of member rights and responsibilities.
    c. Validate that data received from providers is accurate and complete by:
        i. Verifying the accuracy and timelines of reported data, including data from network providers UHA is compensating on the basis of capitation payments.
        ii. Screening data for completeness, logic, and consistency.
        iii. Collecting data from providers in standardized formats to the extent feasible and appropriate.
            1. All provider submissions are received through UHA's third-party administrator delegate.

2. Additionally, UHA validates data as outlined in the Umpqua Health policy QI04 – Data Validation.

iv. Facilitate an electronic health information exchange (HIE) that supports exchange of patient health information among participating providers by identifying current capacity and shall develop and implement any necessary plans for improvement.

v. Making all collected and reported data available upon request to OHA and Centers for Medicare and Medicaid Services (CMS).

Enrollee Encounter Data

1. As required by the CCO contract with OHA, the health information system will provide for:
    a. Collection and maintenance of sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees.
    b. Submission of enrollee encounter data to OHA at a frequency and level of detail as specified by CMS and OHA, based on program administration, oversight, and program integrity needs.
    c. Submission of all enrollee encounter data that OHA is required to report to CMS under 42 CFR § 438.818.
    d. Specifications for submitting encounter data to OHA in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

OHA Review and Validation of Encounter Data

1. OHA must review and validate that the encounter data collected, maintained, and submitted to the State by UHA meets the requirements of 42 CFR § 438.242.
    a. As such, OHA will notify UHA of the status of all encounter data processed.
        i. All encounter data requiring correction shall be done within 63 days of receiving notification.
2. OHA must have procedures and quality assurance protocols to ensure that enrollee encounter data submitted is a complete and accurate representation of the services provided to the enrollees under the contract between the OHA and UHA.

CORPORATE POLICY & PROCEDURE

	Policy Name: Encounter Data Submission and Validation
Department: Claims Administration	Policy Number: CA2
Version: 3	Creation Date: 7/18/2018
Revised Date: 6/19/19, 11/1/19	Review Date:
Line of Business: ☐ All ☒ Umpqua Health Alliance ☐ Umpqua Health - Newton Creek ☐ UHA Community Activities ☐ Professional Coding and Billing Services	☐ Umpqua Health Management ☐ Physician eHealth Services ☐ Umpqua Health Network ☐ ACE Network
Signature: Approved By: Michael A. von Arx, Chief Operating Officer	Date: 1/30/2020

POLICY STATEMENT

As a Coordinated Care Organization (CCO) Umpqua Health Alliance (UHA) must comply with encounter data requirements of Oregon Administrative Rule (OAR) 410-141-3570 (fka 410-141-3430), 943-120-0100 through 943-120-0200, meet the data content and submission standards as required by the Health Insurance Portability and Accountability Act (HIPAA), 45 Code of Federal Regulation (CFR) Part 162, and the Coordinated Care Organization (CCO) Contract with Oregon Health Authority (OHA and Authority) (Exhibit B, Part 8) and the Authority's 837 technical specifications for encounter data and the encounter data submission guidelines.

PURPOSE

To ensure that all encounter data is accurately submitted to OHA by a Third Party Administrator (TPA) and UHA. This policy specifies procedures UHA uses to assess the completeness and accuracy of encounter data submitted by the TPA or by direct submission to OHA. OHA uses encounter data to assess and improve quality, monitor program integrity, and for rate setting purposes.

RESPONSIBILITY

Claims Administration

DEFINITIONS

Encounter Data: A record of healthcare claims/services delivered to UHA beneficiaries by providers, such as doctors and hospitals.

FKA: Formerly known as.

Maintenance Management Information System (MMIS): Is a mechanized claims processing and information retrieval system for Medicaid that is required by the federal government.

	Policy Name: Encounter Data Submission and Validation
Department: Claims Administration	Policy Number: CA2
Version: 3	Creation Date: 7/18/2018
Revised Date: 6/19/19, 11/1/19	Review Date:

National Council for Prescription Drug Programs (NCPDP) Pharmacy Encounter File: The Standardization Committee within the NCPDP maintains a standard format for the electronic submission of third party drug claims and encounter data transactions.

Pharmacy Benefits Manager: An organization contracted to perform administrative services for UHA.

Subject Month: The month in which the date of service occurred that is under review for timely and accurate encounter data submission using the AP standard.

Third Party Administrator (TPA): An organization contracted to perform administrative services such as processing insurance claims for UHA.

The Division of Medical Assistance Programs (DMAP): A part of the Oregon Health Authority (OHA).

Trading Partner Agreement: An agreement in a form of contract related to the exchange of Electronic Data Interchange (EDI) information in electronic transactions. Trading Partner Agreement may include various terms of EDI exchange, such as duties, responsibilities, and liabilities.

PROCEDURES

OHA Requirements for Encounter Data Submission

1. As a CCO, UHA is required to submit encounter data for all covered services except for health-related services, provided to the members as defined in OAR 410-120-0000 and 410-141-3500 (fka 410-141-3000).
2. The encounter data will only be accepted if the file is an 837 professional, institutional, dental claim or an NCPDP pharmacy encounter file.
3. Before submission, the encounters must be validated by the TPA to meet the requirements below:
    a. Verify provider enrollment status.
        i. All providers listed on the encounter claim must be enrolled with OHA.
    b. Verify member eligibility and enrollment.
        i. UHA and the TPA receive a daily and monthly enrollment roster (i.e. 834 files) that list the eligible members currently enrolled.
        ii.
    c. Report third party liability (TPL) and the correct billed and paid dollar amounts as applicable.
    d. Have the correct adjustment reason codes applied.

e. Include the DMAP assigned plan number as indicated in the Oregon MMIS technical specifications.
f. Include the paid amounts on all claims (i.e. fee-for-service (FFS) and capitated) as required by 42 CFR § 438.818.
g. Maintain sufficient data to identify which provider actually delivered the service to the member per Social Security Act (SSA) section 1903(m)(2)(A)(xi).

4. Encounter data that meets these requirements is submitted to OHA via OHA's MMIS Trading Partner mailbox using secure file transfer protocol (SFTP).
5. Participation with the Coordination of Benefits Agreement (COBA) Program which is a standard contract between Centers for Medicare & Medicaid Services (CMS) and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare cross over claims for the purposes of coordinating benefits. UHA has a Trading Partner agreement with COBA and receives cross-over claims for dual eligible members with traditional Medicare per 42 CFR § 438.3(t).
6. The TPA is delegated/contracted to submit all encounter data to OHA that meets the above requirements with the exception of NCPDP Pharmacy files. The TPA generates and submits the professional and institutional encounters. The dental encounters are generated by the Dental Care Organization(s) (DCO) and submitted by the TPA. The pharmacy benefits manager generates the NCPDP pharmacy files which are submitted by UHA.
7. UHA certifies and attests that based on best information, knowledge, and belief, the data, documentation, and information submitted in its encounter claims is accurate, complete, and truthful in accordance with 42 CFR §§ 438.604 and 438.606. This is done by signing the Encounter Data Certification and Validation Report Form (CVF). The CVF must be signed by one of the following:
    a. The Chief Executive Officer (CEO);
    b. The Chief Financial Officer (CFO); or
    c. An individual who has been delegated the authority to sign.
8. UHA will further demonstrate the accuracy, completeness, and truthfulness in its submissions of encounter data by providing the following reports to OHA:
    a. Encounter Data Certification and Validation Report Form;
    b. Encounter Claim Count Verification Acknowledgment and Action Report;
    c. Pharmacy Expense Proprietary Exemption Request Report; and
    d. Pharmacy Expense Report.
9. Administrative Performance Standard (AP Standard) requires the submission of valid encounter data to OHA certified in accordance with OAR 410-141-3570 (fka 410-141-3430). The AP Standards require that encounter data must be submitted at least twice per calendar month, within 45 days of the date of adjudication, and that all corrections are

made within 63 days from the date of notification.. The minimum submissions required is one Pharmacy encounter data file and one Non-pharmacy (dental, institutional, or professional) encounter data file. If the AP Standard is not met on a subject month, OHA will apply a AP withhold to the following calendar month's capitation payment.

10. The submission of all encounter data must be within 45 days of adjudication. Failure to meet the 45-day submission time-frame requires a written Notice of Encounter Data Delay to UHA's encounter data liaison.
    a. The Notice of Encounter Data Delay must be sent to the encounter data liaison prior to or on the date of encounter data submission and informs OHA of the reason for the delay. Some acceptable reasons for delay in submission are:
        i. Member's failure to give the provider necessary claim information;
        ii. Resolving local or out-of-area provider claims;
        iii. Third party resource liability or Medicare coordination;
        iv. Member pregnancy;
        v. Hardware or software modifications to UHA's system that would prevent timely submission or correction of encounter data; or
        vi. OHA recognized system issues preventing timely submission of encounter data.
    b. Upon receipt of the Notice of Encounter Data Delay, OHA will review and make a determination on whether the reason for delay was acceptable. OHA will advise UHA's Contract Administrator via Administrative Notice within 30 days of receipt.
    c. OHA may require UHA to agree to an informal remediation process for any delay in submission, regardless of the reason or the provision of Encounter Data Delay Notice. The Compliance Status Agreement will require the implementation of processes to prevent delays in future submissions.
11. All valid unduplicated medical and dental encounter data must be submitted to OHA at least once per month, adjudicated in the subject month, within 45 days of the date of adjudication and any remaining submissions within 180 days from the date of adjudication. Corrections must be done within 63 days of the date of notification. OHA will initiate a corrective action plan if the encounters submitted exceeds 180 days from the date of service adjudication or more than 5% of the months' submissions are duplicates.
12. All valid unduplicated pharmacy encounter data must be submitted to OHA at least once per month, adjudicated in a subject month, and within 45 days of the dispense date. Corrections must be done within 63 days of the notification. OHA will initiate a corrective action plan if the encounters submitted exceeds 45 days from the claims adjudication date or more than 5% of the months' submissions are duplicates or could not be processed due to missing or erroneous information.

13. All encounter submissions for a subject month will be reviewed by OHA to determine if UHA submitted in accordance with the AP standard. Once the review is complete, OHA will send a Subject Month report within 30 days after the end of the final submission month.
14. The edits applied to encounter data by OHA are listed in the encounter data status file supplemental guide located here: http://www.oregon.gov/oha/HSD/OHP/Pages/Encounter-Data.aspx.
15. Encounter data for the period from January 1 through December 31 (e.g. 12-month period), must be submitted to OHA no later than April 30th, initiating in the year 2021. This is to ensure that encounter data for Hepatitis C DAA drugs is complete and accurate. Encounter data submissions that include dates of service during the Hepatitis C risk corridor period require the following information:
    a. A form specified by OHA, accompanied by an attestation that all Hepatitis C DAA drugs that are 340B drugs were reimbursed at the 340B entity's actual acquisition cost, plus the contractor's usual allowed dispensing fee.

Capability of Systems

1. UHA has delegated the following to its TPA:
    a. Information Systems:
        i. Data Processing and Procedures;
        ii. Data Base Management System (DBMS);
        iii. Programming language; and
        iv. Process for updating the program to meet changes in State requirements.
    b. Claims/Encounter Processing:
        i. Overview of the processing of encounter data submissions;
        ii. Completeness of the data submitted; and
        iii. Policies/procedures for audits and edits.
    c. Claims/ Encounter System Demonstration:
        i. Processes for merging and/or transfer of data;
        ii. Processes for encounter data handling, logging and processes for adjudication audits performed to assure the quality and accuracy of the information and the timeliness of processing, and
        iii. Maintenance and updating of provider data.
    d. Enrollment Data
        i. Verification of claims/encounter data;
        ii. Frequency of information updates; and
        iii. Management of enrollment/disenrollment information.

Analyzing Encounter Data

	Policy Name: Encounter Data Submission and Validation
Department: Claims Administration	Policy Number: CA2
Version: 3	Creation Date: 7/18/2018
Revised Date: 6/19/19, 11/1/19	Review Date:

1. UHA determines the validity of encounter data submitted based on the results of the submission of encounter data to OHA. The Data Reconciliation Analysts tracks rejections, generates and reviews analytic reports. An acceptance rate of 95% is considered acceptable. Any notable data quality issues are reported to the Chief Operating Officer and the Compliance Manager. The UHA Compliance Department will address any provider specific data quality issues.

Encounter Data Quality Testing

1. To ensure that there are not any missing encounter submissions, the following reports are utilized:
    a. The UHA Lag Report.
        i. Used to reconcile number of medical claims submitted for encounter per check-run.
    b. The Record Count Report from the pharmacy benefits manager.
        i. Used to track for the number of pharmacy claims submitted for encounter.
    c. The UHA Dental Import Summary Report.
        i. Used to track for the number of dental claims submitted for encounter.
    d. Control Log Report.
        i. Used to Track all 837 transaction file submissions.
    e. UHA Submission Tracker.
        i. Used to validate the encounters submitted in the 837 file were received by OHA.
    f. Claims Inventory Report.
        i. Used to track the total number of claims paid/processed per check run.

Generating and Reviewing the Analytical Reports

1. UHA compiles and tracks the following to analyze the volume and consistency of encounter data.
    a. Number of members per month.
    b. Number of claims processed per month.
    c. Number of encounters submitted per month.
    d. Number of encounters accepted.
        i. Acceptance rate.
    e. Number of encounters rejected.
        i. Total number of rejections.
        ii. The most common rejection reason.
2. These data points are tracked by type of service (claim type):
    a. Pharmacy;

b. Professional;
c. Institutional; and
d. Dental.

3. The data compiled is compared to previous months submissions to identify any data trends that merit investigation.
    a. Any concerns are first brought to the attention of the submitter, the submitter may be a delegated entity, to confirm that the anomaly is an issue.
    b. Once the issue has been identified and confirmed by the Data Reconciliation Analyst, the results are reviewed by the Director of Claims Operations to determine if the issue has been resolved or if further action is needed.
        i. If further action is needed to ensure provider compliance with the contract or the compliance of the delegated entity, the issue is reported to the Compliance Department and upper management (e.g. the Chief Operating Officer). The Chief Operating Officer will determine if any action such as a chart review is required.

<u>Encounter Data Validation Audit Program</u>

1. UHA has an encounter data auditing program to ensure its encounters submitted meet OHA requirements for timeliness, completeness, and accuracy.
    a. The program consists of:
        i. Comparing encounter data submission trends (e.g. trends in 2018 with data trends in 2019).
        ii. Investigate any data anomalies found.
            1. Findings could result in a member level chart review consisting of comparing the individual encounter with the medical record to determine if the diagnosis and service information submitted was complete and accurate.
        iii. A defined quarterly audit of claims submitted to encounter.
            1. Sample size will reflect the percentage of claims processed that quarter.
    b. Based on findings, OHA may require UHA to engage remediation activities as stipulated in the CCO Contract (Exhibit B, Part 9(m)).
2. UHA will complete chart reviews to validate if the medical record substantiates what the provider has billed. Focus areas for review will be driven by utilization and then claims/encounters will be selected at random from that data set.
    a. If errors in provider billing are identified, UHA will take action which may include provider training, corrective action plans, or possible recoupment in accordance with Oregon Administrative Rules and contractual requirements.

	Policy Name: Encounter Data Submission and Validation
Department: Claims Administration	Policy Number: CA2
Version: 3	Creation Date: 7/18/2018
Revised Date: 6/19/19, 11/1/19	Review Date:

All Plan System Technical Meeting

1. UHA staff responsible for the submission and validation of encounter data will attend OHA's All Plan System Technical meeting to stay informed of all new business and technology related issues.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A

UMPQUA HEALTH

CORPORATE POLICY & PROCEDURE

	Policy Name: Grievances
Department: Clinical Engagement	Policy Number: CE01
Version: 9	Creation Date: 7/9/2008
Revised Date: 1/26/17, 1/17/18, 2/9/18, 8/14/18, 7/23/19, 10/22/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature: F Douglas Carr, MD

Approved By: F. Douglas Carr, MD, Chief Medical Officer Date: 10/29/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, a member's representative, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3835 through 410-141-3915 (fka 410-141-3225 through 410-141-3255), and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, appeals, hearings, and member services.

PURPOSE

To provide all members with a meaningful, confidential process to file a grievance.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR § 438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.
Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within

the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: A request by a UHA member or a member's representative to review an adverse benefit determination. For purposes of this policy, an appeal also includes a request by OHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

FKA: Formerly known as.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the UHA to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make Oregon Health Plan (OHP) related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in Oregon Revised Statutes (ORS) 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Authority (OYA), the member representative is DHS or OYA. For members placed by DHS through a

Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

PROCEDURES

1. UHA provides members with written information regarding the grievance process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (also see policies MS3 - Member Rights and MS9 – Member Handbook);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service;
    e. When UHA extends the timeframe of a service authorization, or fails to meet the required timeframe; and
    f. At any time upon request.
2. UHA will ensure all staff who have contact with members or potential members are fully informed of UHA's Grievance policy.
3. UHA requires all participating providers and subcontractors to comply with the Grievance and appeal system requirements set forth in the CCO Contract (Exhibit I).
    a. UHA will provide every provider and subcontractor at the time it enters into a contract or subcontract its OHA approved written procedures for its Grievance and Appeals System.
    b. UHA will provide all of its participating providers and subcontractors with written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.
4. UHA will provide members with oral information regarding the grievance and appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
5. UHA will make its grievance forms including those listed in OAR 410-141-3875(11) (fka 410-141-3230(11)) available and accessible to its members in all administrative offices. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format).

6. Member grievance and appeals resolution process will protect the anonymity of complaints and protect callers from retaliation.
7. UHA will ensure members that all information concerning a member's grievance will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance, have a right to use this information, without a signed release from the member, for purposes of:
        i. UHA resolving the grievance;
        ii. For purposes of maintaining the appropriate logs; and/or
        iii. For health oversight purposes by OHP.
    b. If UHA must release any information related to the grievance to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. Without a signed authorization, some information cannot be released which may restrict UHA's investigation.
8. A member grievance may be received in writing or orally. Any time a member expresses dissatisfaction or concern they are informed of their right to file a grievance and how to do so at any time for any matter other than an Adverse Benefit Determination. UHA, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
9. If the member files a grievance with OHA, OHA will then forward promptly to UHA for handling.
10. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to grievances. Upon receipt of a grievance, UHA obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.
11. UHA will acknowledge receipt of a grievance to the member within five (5) working days, as part of the notifications below.
    a. Each grievance is investigated and resolved as expeditiously as the member's health condition requires and within the following timeframes:
        i. For standard disposition of a grievance, within five (5) working days

from the date of receipt, UHA will make a decision and notify the member; or

ii. Within five (5) working days notify the member in writing that a delay of up to 30 calendar days from the date of receipt is necessary to resolve the grievance. If a delay is needed to resolve the grievance UHA shall specify the reasons the additional time is necessary. An extension up to 30 calendar days may also occur at the member's request.

12. UHA ensures that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 (fka 410-141-3230) MCE Grievance and Appeals System General Requirements.
13. UHA will ensure that any staff or consulting experts making decisions on the grievance are:
    a. Not involved in any previous level of review or decision making nor a subordinate of such individual with respect to the grievance;
    b. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall also make decisions pertaining to a grievance regarding denial of expedited resolution of an appeal or involves clinical issues; and
    c. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
14. If UHA's failure to meet a required timeframe for review precipitated the grievance, UHA will work with the member and provider(s) to coordinate care and address the original request as appropriate.
15. A written response will be provided whether the member filed their grievance orally or in writing. The notice of grievance resolution shall:
    a. Address each aspect of the member's grievance and the reason for UHA's decision.
    b. Comply with OHA's formatting and readability standards in OAR 410-141-3585 (fka 410-141-3300) and 42 CFR § 438.10. UHA shall write the notice in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing the grievance resolution.
    c. The process for members who are dissatisfied with the disposition of a grievance to present their grievance to the DHS Client Services Unit or OHA's Ombudsman.

i. UHA and its subcontractors will promptly cooperate with any investigations and resolution of a grievance by either or both DHS' Client Services Unit and OHA's Ombudsperson as expeditiously as the member's health condition requires, and within timeframes set forth in the CCO Contract.

16. All grievances are placed in Clinical Engagement's quarterly grievance log. This log is reviewed quarterly for quality improvement purposes and submitted to the State to review as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO Contract deliverables.
17. Data from grievances may also be utilized to identify and report, as needed, trends impacting members, UHA, its subcontractors, or its participating providers. Information is also reported to multiple committees for review.
18. In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, UHA reviews and reports to the OHA, as outlined in the CCO Contract, complaints that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.
19. Grievance documentation shall be accurately maintained in a manner accessible to the state and available to CMS upon request for 10 years (CCO Contract Exhibit I, Section 9 and CO23 – Record Retention & Destruction Policy).

Subcontracted Entities

1. If UHA delegates the grievance process to a subcontractor, it must:
    a. Provide to OHA all subcontracts for grievance services to be approved prior to such subcontracts being implemented (CCO Contract Exhibit B, Part 3, Section 14(c)(4).
    b. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 (fka 410-141-3225 through 410-141-3255) and 42 CFR §§ 438.400 through 438.424;
    c. Monitor the subcontractor's performance on an ongoing basis;
    d. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
    e. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
    f. Data collected by subcontractors and participating providers are included in UHA's analysis of grievance system data provided to OHA consistent with contractual requirements (see procedure #16-17 above).

2. Subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. Grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.

UMPQUA HEALTH

CORPORATE POLICY & PROCEDURE

	Policy Name: Appeals and Hearings
Department: Clinical Engagement	Policy Number: CE20
Version: 9	Creation Date: 7/9/2008
Revised Date: 8/14/18, 4/1/19, 7/23/19, 10/22/19	Review Date:
Line of Business: ☐ All	
☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network
Signature: F Douglas Carr, MD. Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 10/29/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) has internal grievance procedures under which members, or providers acting on their behalf, may challenge an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), OAR 410-141-3875 through 410-141-3915 (fka 410-141-3230 through 410-141-3255), and 42 CFR §§ 438.400 through 438.424. This policy applies in conjunction with related policies for adverse benefit determinations, member grievances, and member services.

PURPOSE

To provide all members with an appropriate means to appeal an adverse benefit determination.

RESPONSIBILITY

Member Services
Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR § 438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of

grievances and appeals; the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: A request by a UHA member or a member's representative for UHA to review an adverse benefit determination.

Clinical Advisory Panel: A panel comprised of practicing doctors and other health care experts.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

FKA: Formerly known as.

Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian. For the purpose of this policy, references to "member" may also include "member representatives." This may also include the legal representative of a deceased member's estate.

Member Representative: A person who can make OHP related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in ORS 127.505(13) (including an attorney-in-fact or a court-

appointed guardian), a spouse, or other family member as designated by the member, the

Timely Filing (as it applies to continuation of benefits): Means filing no later than the 10th day following the adverse benefit determination (ABD) or the notice of appeal resolution, or by the effective date of the proposed adverse benefit determination.

PROCEDURES

Appeals

1. A member that disagrees with an ABD may file an appeal. UHA provides members with written information regarding the appeal and hearing process:
    a. Upon initial enrollment to OHP via the Client Handbook;
    b. Upon initial enrollment to UHA via the Member Handbook (see also policy MS3-Member Rights);
    c. Upon denial of a request for service;
    d. Upon discontinuance of a previously authorized service; and
    e. At any time upon request.
2. UHA will provide members with oral information regarding the appeal process upon request, or when a member or representative expresses concern or dissatisfaction.
3. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format).A member or a subcontractor or provider with the member's written consent who disagrees with an ABD or is contesting the failure of UHA to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals may file an appeal with UHA.
4. UHA has one level of appeal for members, and members shall complete the appeals process with UHA prior to requesting a contested case hearing.
    a. UHA will acknowledge the receipt of an appeal to the member in writing for standard resolutions within five (5) business days of receipt.
    b. Expedited appeals are acknowledged orally and in writing within one (1) business day of receipt.
5. For standard resolution of an appeal and notice to the affected parties, UHA shall establish a timeframe that is no longer than 16 days from the day UHA receives the appeal:
    a. If UHA fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted UHA's appeals process. In

this case, the member may initiate a contested case hearing;

b. UHA may extend the timeframes by up to 14 days if:
    i. The member requests the extension; or
    ii. UHA shows to the satisfaction of the Authority, upon its request, that there is need for additional information and how the delay is in the member's interest.
c. If UHA extends the timeframes, but not at the request of the member, it shall:
    i. Make reasonable efforts to give the member prompt oral notice of the delay; and
    ii. Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

6. For expedited resolution of an appeal, UHA will complete the review in a timeframe that is no longer than 72 hours after receipt when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in OAR 410-141-3895 (fka 410-141-3246).
7. The review timeframe for an expedited review may be extended by up to 14 days if:
    a. The member requests the extension; or
    b. UHA shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.
8. If UHA extends the expedited timeframes not at the request of the member or denies a request for an expedited appeal, then it will:
    a. Make reasonable efforts to give the member prompt oral notice of the delay;
    b. Within two (2) calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and
    c. Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860.
9. All appeals that are granted extensions are resolved no later than the expiration date of the extension.
    a. If UHA approves a request for expedited appeal but denies the services or items requested in the expedited appeal, UHA will:
        i. Inform member of their right to request an expedited contested case hearing and send the member a Notice of Appeal Resolution (NOAR), Hearing Request and Information form as outlined in OAR 410-141-3890 (fka 410-141-3245).
10. The ABD notices and Appeal and Hearing Request form (OHP 3302) provides information on member's rights and the process for appealing:

a. If after filing an oral appeal, a member or the provider on the member's behalf does not submit a written appeal request within the appeal timeframe, the appeal shall expire;
b. UHA shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution;
c. UHA does not need to notify the member if it has already made attempts to assist the member in filling out the necessary forms to file a written appeal.
d. The date of an oral appeal request will be treated as the received or filing date.

11. UHA, its subcontractors, and its participating providers may not:
    a. Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
    b. Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
    c. Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment.
12. A member, their representative, legal representative of a deceased member's estate, or the provider on the member's behalf may request an appeal either orally or in writing directly to UHA for any notice or failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of appeals by UHA:
    a. UHA shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;
    b. The member shall file the appeal with UHA no later than 60 days from the date on the notice.
13. UHA will ensure members that all information concerning a member's grievance or appeal will be kept confidential.
    a. UHA and any practitioner whose services, items, quality of care, authorization, treatment, or request for payment is alleged to be involved in the grievance or appeal, have a right to use this information for purposes of UHA resolving the grievance or appeal, for purposes of maintaining the appropriate logs, and for health oversight purposes by OHP, without a signed release from the member.
    b. If UHA must release any information related to the grievance or appeal to any other person or party, UHA will ask the member to sign an authorization to release information prior to disclosing such information. UHA's investigation may be restricted and information will not be released without a signed authorization.
14. UHA ensures that the individuals who make decisions on appeals follow all

requirements in OAR 410-141-3875 (fka 410-141-3230) MCE Grievance and Appeals System General Requirements:

a. Ensure staff and any consulting experts making decisions on the appeal are: Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.
b. Decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

15. The Appeal & Grievance Coordinator is responsible for receiving, processing, directing, and responding to appeals. Upon receipt of the appeal, the coordinator:
    a. Obtains documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member or their representative.
    b. Investigates and resolves as expeditiously as the member's health condition requires and within the timeframes stated above for standard and expedited appeals.
    c. Provides members a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.
    d. Informs members of the limited time available to present evidence and testimony, in person and in writing, and make legal and factual arguments in the case of an expedited appeal resolution. UHA informs members of this sufficiently in advance of the resolution timeframe for appeals.
16. UHA will ensure that any staff or consulting experts making decisions on the grievance are:
    a. Not involved in any previous level of review or decision making nor a subordinate of such individual;
    b. Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance involves clinical issues or if the member requests an expedited review. Health care professionals shall also make decisions pertaining to a grievance regarding denial of expedited resolution of an appeal or involves clinical issues; and
    c. Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or

entity to deny, limit, or discontinue medically necessary services to any member.

17. UHA must continue the member's benefits while an appeal is in process if all the criteria is met in the Continuation of Benefits section of this policy below.
18. UHA will provide members a copy of their case file (including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by UHA (or at the direction of UHA) in connection with the appeal of the adverse benefit determination. UHA provides the case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.
19. The member will be notified in writing with a notice of appeal resolution consistent with the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885 (fka 410-141-3240), and the Authority's formatting and readability standards in OAR 410-141-3585 (fka 410-141-3300), 42 CFR §§ 438.408, and 438.10. UHA will also make reasonable effort to provide the member with oral notice of the resolution. This includes but is not limited to the following content and format:
    i. The results of the appeal resolution.
    ii. The date of the appeal resolution.
    iii. Written in language sufficiently clear that a layperson could understand the notice and make an informed decision (about appealing and following the process for requesting a hearing if applicable).
    iv. The process for requesting a hearing if applicable:
        1. The rules that govern representation at a hearing.
        2. The right to have an attorney or member representative present, and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline 1-800-520-5292, TTY711.
20. If the original ABD is upheld wholly or partially, a notice is also mailed with the Appeal and Hearing Request Form (OHP 3302) explaining that they may file a hearing within 120 calendar days of the date of the notice of appeal resolution A request for an OHA administrative hearing made without previous use of the appeal procedures may be forwarded to UHA to review as an appeal prior to the hearing.
    a. If UHA had reinstated or continued the 's benefits pending the appeal, the benefits must be continued pending an administrative hearing.
    b. If a portion of the request was overturned, UHA would also indicate in the notice details of those services that had a favorable outcome.
21. If the original ABD is overturned, UHA will issue a notice of appeal resolution within the required timeframes and must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from

the date of notice reversing the determination. the UHA must promptly correct the ABD taken up to the limit of the original request or authorization.

22. In the case that UHA fails to adhere to notice and timing requirements, the member is deemed to have exhausted the appeals process and may initiate a hearing.
23. The Appeal and Hearing Request Form (OHP 3302) is available on the OHA website, at Member Services, UHA's Clinical Engagement Office, and can be mailed to the member upon request.
24. UHA's participating providers are provided information about the Grievance System at the time they enter into a contract with UHA via provider orientation and training (PN6 – Provider Orientation & Training). This information is also available on the UHA website under the Provider Handbook section.
25. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format (e.g. auxiliary aids), or would like a qualified or certified interpreter, they may contact UHA Member Services for assistance by going to the office, calling the standard phone number, or by using the TTY or TTY toll free phone number; all contact information is posted on UHA's public website (MS5 – Requests for Interpreter or Alternative Format). All appeals shall be documented in writing on the quarterly report log and an appeal chart must be created. The quarterly report log is submitted to the State as part of the State quality strategy. Categories and service types are applied consistent with Exhibit I of the CCO Contract deliverables.
26. Appeal trends may be reported to the Clinical Advisory Panel (CAP).

Continuation of Benefits

1. A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount as previously authorized while an appeal or hearing is pending.
2. Timely filing means filing on or before the later of the following:
    a. Within ten (10) days after the date of the ABD; or
    b. The intended effective date of the action proposed by the ABD.
3. UHA will continue the member's benefits if all of the following apply:
    a. The member or member's representative timely files the appeal or hearing request.
    b. The appeal or hearing request involves the termination, suspension, or reduction of previously authorized services.
    c. An authorized provider ordered the services.
    d. The period covered by the original authorization has not expired.
    e. The member timely files for continuation of benefits.
4. The duration of continued benefits pending an appeal resolution if at the member's request will continue until one of the following occurs:

   a. The member withdraws the appeal.
   b. UHA issues an appeal resolution.
   c. The original authorization expires or the authorization service limits are met.
5. The duration of continued benefits pending a hearing resolution if at the member's request will continue until one of the following occurs:
   a. The member does not request a hearing within 10 days from when UHA mails the NOAR.
   b. The member withdraws the appeal.
   c. UHA issues an appeal resolution.
   d. The original authorization expires or the authorization service limits are met.
6. If the final resolution of the appeal or hearing upholds UHA's ABD, UHA may recover from the member the cost of the services furnished to the member while the appeal or hearing was pending (see CCO Contract Exhibit I, section 6).

Administrative Hearings

1. A member may request a contested case hearing with the Authority after receiving notice that UHA notice of ABD is upheld or, in the case of UHA failing to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider that the member has exhausted the appeals process and may initiate a contested case hearing.
2. If the member files a request for an appeal or hearing with the Authority prior to the member filing with UHA, the Authority shall transfer the request to UHA and provide notice of the transfer to the member.
3. OHA must receive the member's hearing request within 120 days of the date shown on the Notice of Appeal Resolution.
4. If the member requested that UHA continue or reinstate services while the appeal was pending, benefits must be continued pending the administrative hearing until one of the following:
   a. The member withdraws the administrative hearing request;
   b. 10 calendar days have passed after UHA notice of appeal resolution was issued and the member failed to request continuation of benefits;
   c. A final order is issued to a member with an adverse resolution to that member; or
   d. The time period or service limits of a previously authorized service have been met.
5. OHA will review the administrative hearing request and verify that the member was a UHA member at the time the ABD was taken and whether the hearing request was timely.
   a. Should UHA receive the administrative hearing request, UHA shall transmit that request to OHA including a copy of the member's ABD or notice of appeal resolution, as applicable, immediately.

6. Once OHA receives a valid administrative hearing request they will send a copy of the hearing request to UHA.
7. UHA shall cooperate with providing relevant information required for the hearing process to OHA on all administrative hearings within two (2) business days. This includes expedited hearings.
    a. An administrative notice of all documentation UHA relied upon to make its initial and appeal decisions.
    b. Copies of hearing requests, ABD, and NOAR.
8. If the hearing request is received by UHA from the member, UHA will date stamp the request and forward the request to OHA, following procedure #7 above
9. Information regarding the member used for administrative hearings is handled in confidence.
    a. OHA, the member, their representative or the legal representative of a deceased member's estate, UHA, and any practitioner whose authorization, treatment, services, items, or request for payment is involved in the administrative hearing have a right to use this information for purposes of resolving the administrative hearing without a signed release from the member.
    b. OHA may also use this information for health oversight purposes and for other purposes authorized or required by law.
    c. The information may also be disclosed to the Office of Administrative Hearings and the administrative law judge assigned to the administrative hearing and to the Court of Appeals if the UHA member seeks judicial review of the final order.
    d. OHA will ask the member to authorize a release of information regarding the administrative hearing to any other individual.
10. The hearing will be scheduled through the Office of Administrative Hearings. Parties to the administrative hearing shall include UHA, the member, the member's representative or legal representative of a deceased member's estate and provider acting on behalf of a member, with written consent from the member.
11. A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.
12. The Authority shall issue a final order or the Authority shall resolve the case ordinarily within 90 days from the date UHA receives the member's request for appeal. This does not include the number of days the member took to subsequently file a contested case hearing request. The final order is the final decision of OHA.
13. For reversed appeal and hearing resolution services:
    a. For services not furnished while the appeal or hearing is pending. If UHA or

the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, UHA shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;

b. For services furnished while the appeal or hearing is pending. If UHA or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, UHA or the state shall pay for those services in accordance with the Authority policy and regulations.

14. Should the administrative hearing decision uphold UHA's adverse benefit determination, UHA may recover the cost of service furnished to the member while the hearing is pending pursuant to 42 CFR § 431.230(b), to the extent that they were furnished solely because of the requirements of Exhibit I, Section 6 of the CCO Contract.

Documentation and Quality Improvement

1. UHA shall have a grievance chart for each grievance and appeal. The chart should include record of the review/investigation, resolution, written decisions, and copies of correspondence. UHA shall retain documentation of appeals for the term of 10 years to permit evaluation (CO23 – Record Retention & Destruction Policy).
2. Each appeal and grievance shall be documented in the appropriate log. The quarterly report and grievance log shall be consistent with OHA requirements of the Exhibit I of CCO Contract deliverable.
3. All written decisions and copies of all correspondence with all parties to the appeal. The grievance coordinator is responsible for monitoring both appeals and grievances for completeness, accuracy, and timeliness of documentation, compliance with policies and procedures, and compliance with Oregon Health Plan Rules.
4. All quarterly reports are reviewed by the CAP.

Subcontracted Entities

1. If UHA subcontracts the grievance and appeal (see also #4 below) process to a subcontractor, it must:
    a. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 (fka 410-141-3225 through 410-141-3255);
    b. Monitor the subcontractor's performance on an ongoing basis;
    c. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and

   d. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Subcontractors must also comply with the following guidelines:
   a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
   b. Notice of appeal resolutions will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.
4. UHA shall not subcontract to a subcontractor or participating provider the adjudication of an appeal, in accordance with OAR 410-141-3875(14) (fka 410-141-3230(12)).

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Clinical Engagement	Appeals	SOP-CE20-1	7/24/19	1
Clinical Engagement	Hearings	SOP-CE20-2	7/24/19	1

CORPORATE POLICY & PROCEDURE

	Policy Name: Adverse Benefit Determinations
Department: Clinical Engagement	Policy Number: CE21
Version: 4	Creation Date: 8/14/18
Revised Date: 4/1/19, 10/23/19	Review Date: 7/23/19
Line of Business: ☐ All	
☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network
Signature: F Douglas Carr, MD Approved By: F. Douglas Carr, MD, Chief Medical Officer	Date: 10/29/19

POLICY STATEMENT

Umpqua Health Alliance (UHA) issues written notification to members when it has made or intends to make an adverse benefit determination. UHA shall maintain its policies in accordance with the Coordinated Care Organization (CCO) Contract between UHA and the Oregon Health Authority (OHA, Authority, or State), Oregon Administrative Rules (OAR) 410-141-3835 through 410-141-3915 (fka 410-141-3225 through 410-141-3255), and Code of Federal Regulations (CFR) 42 CFR §§ 438.400 through 438.424. This policy is applied in conjunction with the policies for prior authorizations, grievances, appeals, hearings and member services (i.e. Member Handbook).

PURPOSE

To provide all members with opportunity to appeal an adverse benefit determination.

RESPONSIBILITY

Clinical Engagement

DEFINITIONS

Action: The denial or limited authorization of a requested covered service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Oregon Health Authority (OHA); the failure to act within the timeframes provided in 42 CFR §438.408(b); or for a UHA member in UHA's service area, the denial of a request to obtain covered services outside of UHA's participating provider panel.

Adverse Benefit Determination (ABD): The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service or the denial of payment for a service; failure to provide services in a timely manner, as defined by the State; the failure of UHA to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of

grievances and appeals; the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network if they are a resident of a rural area with only one managed care organization; and the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

Appeal: A request for review of an adverse determination, action or as it relates to an ABD issued by UHA. Members have one level of appeal with UHA.

FKA: Formerly known as.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision.

Grievance System: The overall system that includes grievances and appeals handled at UHA and access to the OHA administrative hearing process.

Member Representative: A person who can make Oregon Health Plan (OHP) related decisions for a member who lacks the ability to make and communicate health care decisions to health care providers, including communication through person's familiar with the principal's manner of communicating if those persons are available. A member representative may be, in the following order of priority, a person who is designated as the member's health care representative as defined in Oregon Revised Statutes (ORS) 127.505(13) (including an attorney-in-fact or a court-appointed guardian), a spouse, or other family member as designated by the member, the Individual Service Plan Team (for members with developmental disabilities), parent or legal guardian of a minor below the age of consent, a Department of Human Services (DHS) or OHA case manager or other DHS or OHA designee. For members in the care or custody of DHS Children, Adults, and Families (CAF) or Oregon Youth Association (OYA), the member representative is DHS or OYA. For members placed by DHS through a Voluntary Child Placement Agreement (SCF form 499), the member representative is his or her parent or legal guardian.

PROCEDURES

1. UHA issues a written notification approved by OHA for an ABD, for any of the following:

a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
b. The reduction, suspension, or termination of a previously authorized service.
c. The denial, in whole or in part, of payment for a service.
d. The failure to provide services in a timely manner, as defined by the State.
e. The failure of UHA to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
f. For a resident of a rural area with only one managed care organization, the denial of a member's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.
g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

2. The ABD notifies the member and requesting provider in writing by meeting the notice requirements of 42 CFR § 438.404 and OAR 410-141-3885 (fka 410-141-3240) by including the Appeal and Hearing Request Form (OHP 3302) and including the following:
    a. Date of the notice;
    b. UHA's name, address, and telephone number;
    c. Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
    d. Member's name, address, and member ID number;
    e. Service requested or previously provided and the ABD UHA made or intends to make, including whether UHA is denying, terminating, suspending, or reducing a service or denial of payment;
    f. Date of the service or date service was requested by the provider or member;
    g. Name of the provider who performed or requested the service;
    h. Effective date of the ABD if different from the date of the notice;
    i. Whether UHA considered other conditions such as co-morbidity factors if the service was below the funding line on the OHP Prioritized List of Health Services; statement of intent governing the use and application of the Prioritized List to requests for health care services, and other coverage for services addressed in the State's 1115(a) Waiver;
    j. Clear and thorough explanation of the specific reasons for the adverse benefit rules including specific sections of the statues and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the notice that includes, but is not limited to:
        i. The item requiring prior authorization but not authorized;

ii. The services or treatment requested not meeting medically necessary or medically appropriate criteria as defined in OAR 410-120-0000;
iii. The service specifically not a covered service or that does not meet requirements based on the Prioritized List of Health Services;
iv. The service or item received in an emergency care setting that does not qualify as an emergency service;
v. The person is not a member at the time of the service or not a member at the time of the requested service;
vi. Except in the case of an Indian Health Care Provider (HCP) serving an Indian (AI/AN) member of the CCO, the provider not on the contractor's panel;
vii. Prior approval not obtained (except as allowed in OAR 410-141-3840 (fka 410-141-3140)); or
viii. UHA's denial of member's disenrollment request and findings that there is no good cause for the request.

3. The ABD and attached Appeal and Hearing Request Form (OHP 3302) also explain the following to the member:
   a. The member's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
   b. Circumstances under which an appeal process can be expedited and how to request it.
   c. The member's right to have benefits continue pending the resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services.
   d. The member's right to have benefits continue pending the resolution of the appeal [to be entitled to continuing benefits, the member shall complete a UHA appeal request or an Authority contested case hearing request for continuing benefits no later than:
      i. The tenth day following the date of the notice of ABD or the notice of appeal resolution (NOAR); and
      ii. The effective date of the action proposed in the notice, if applicable.
   e. The member's right to request an appeal within 60 days from the date of notice on the ABD.
   f. The member's right to request a hearing within 120 days from the date of notice on the NOAR.

4. The notice must comply with the OHA's formatting and readability standards in OARs 410-141-3580 (fka 410-141-3280), 410-141-3585 (fka 410-141-3300) and 42 CFR § 438.10, including, without limitation, translating a notice of adverse benefit determination (ABD) for those members who speak prevalent non-English language and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal.
5. UHA provides notice of an ABD expeditiously as the member's condition requires within state-established timeframes for authorization requests consistent with OAR 410-141-3835 (fka 410-141-3225):
    a. For standard authorization requests for services not previously authorized, provide notice as expeditiously as the member's condition requires and no later than 14 days following receipt of the request for service with a possible extension of up to 14 additional days if the following applies:
        i. The member, the member's representative, or provider requests an extension; or
        ii. UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via administrative notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
    b. For notice of actions/ABD that affect services previously authorized, UHA shall mail the notice at least ten days before the date the ABD takes effect:
        i. UHA shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service;
        ii. UHA may extend the 72-hour time period up to 14 days if the member requests an extension or if UHA justifies to the Authority upon request a need for additional information and how the extension is in the member's interest. UHA must provide its justification to OHA via Administrative Notice to the email address identified by OHA in its request, within five (5) days of OHA's request.
    c. If UHA extends the ABD timeframe for standard or expedited authorization decisions that deny or limit services, it must:
        i. Give the member written notice and make reasonable effort to give oral notice of the reason for the extension and inform the member of the right to file a grievance if he/she disagrees with the decision.
        ii. Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

d. UHA mails the notice of ABD by the date of the action when any of the following occur:
   i. The recipient has died.
   ii. The member submits a signed written statement requesting service termination.
   iii. The member submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
   iv. The member has been admitted to an institution where he or she is ineligible under the plan for further services.
   v. The member's address is determined unknown based on returned mail with no forwarding address.
   vi. The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
   vii. A change in the level of medical care is prescribed by the member's physician.
   viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
   ix. The transfer or discharge from a facility will occur in an expedited fashion.
   x. Any service authorization decision not reached within the timeframes specified in this rule shall constitute a denial and becomes an ABD. A notice of action/ABD shall be issued on the date the timeframe expires.
   xi. For ABDs for long term psychiatric care (LTPC) transfers, the safety or health of individuals in the facility would be endangered, the member's health improved sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent medical needs, or a member has not resided in the LTPC for 30 days.

e. UHA mails the notice of ABD at least 10 days before the date of action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services. UHA may mail the ABD as few as five (5) days prior to the date of action if the agency has facts indicating that action should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources.

6. UHA will give notice on the date that the timeframes expire when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations.
7. UHA maintains a record of each ABD, appeal, and grievance in a manner accessible to

the state and available upon request to the Centers for Medicare & Medicaid Services. Records shall be retained for ten years (CO23 – Record Retention & Destruction Policy).

8. In addition to the content of the ABD and the Appeal and Hearing Request Form (OHP 3302), members may also access information regarding their rights to an appeals, hearing, and grievance on the UHA website and in the Member Handbook.
9. If a member expresses that they need assistance in filling out any forms, requests a notice in a different language or format, or would like an interpreter, they may contact UHA member services for assistance.

Subcontracted Entities

1. If UHA subcontracts the prior authorization, appeal, or grievance process to a subcontractor, it must:
    a. Provide to OHA all subcontracts for grievance services to be approved prior to such subcontracts being implemented (CCO Contract Exhibit B, Part 3, Section 14(c)(4).
    b. Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3835 through 410-141-3915 (fka 410-141-3225 through 410-141-3255) and 42 CFR §§ 438.400 through 438.424;
    c. Monitor the subcontractor's performance on an ongoing basis;
    d. Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
    e. Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.
2. Subcontractors must also comply with the following guidelines:
    a. Maintain a log according to the criteria specified by OHA and submit to UHA no later than 21 days after the end of each quarter.
    b. ABD, NOAR, and grievance resolution notices (as applicable) will be sent by the subcontractors on UHA's behalf. Copies of notices issued will be submitted to UHA no later than 21 days after the end of each quarter.
3. For hearings, subcontractors will forward all documentation to OHA and UHA and coordinate schedules to be available as expert witness during the hearing process.
4. UHA shall not subcontract to a subcontractor or participating provider the adjudication of an appeal, in accordance with OAR 410-141-3875(14) (fka 410-141-3230(12)).

CORPORATE POLICY & PROCEDURE

	Policy Name: Data Backup and Storage
Department: PeHS	Policy Number: H19
Version: 4	Creation Date: 8/1/2011
Revised Date: 11/29/2017	Review Date:

Line of Business: ☒ All

☐ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health - Transitional Care

Signature:

Approved By: Michael von Arx, Chief Operating Officer Date: 3/29/2018

POLICY STATEMENT

Umpqua Health must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA implementing regulations pertaining to data backup and storage, in accordance with the requirements of 45 CFR 164.308(a)(7) and CFR 164.310(d)(2). Failure to comply with these regulations may result in such consequences as monetary penalties, imprisonment, and/or loss of license.

PURPOSE

The purpose is to ensure exact retrievable copies of electronic protected health information are available in case of unexpected events (i.e. natural disaster, equipment failure and/or accidental removal of files). The ability to create and maintain retrievable, exact copies of individually identifiable health information is a critical element of business operations.

RESPONSIBILITY

Physician eHealth Services (PeHS)

DEFINITIONS

Protected Health Information (PHI): Any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity (or a business associate of a covered entity), and can be linked to a specific individual.

PROCEDURES

1. All mission critical data is duplicated in real-time to other servers located at an offsite facility. This includes:
    a. File servers (e.g. R Drive);
    b. Electronic Medical Record (EMR) database;
    c. Scanned documents (e.g. Docutrak); and,
    d. Email database.

	Policy Name: Data Backup and Storage
Department: PeHS	Policy Number: H19
Version: 4	Creation Date: 8/1/2011
Revised Date: 11/29/2017	Review Date:

2. PeHS backs up all servers and databases that house critical business data and electronic PHI on a regular basis to an offsite facility.
    a. Backup software is configured to run backups automatically on a daily schedule;
    b. Backup software is configured to run month-end backups automatically on a monthly schedule; and,
    c. Backup software validates the integrity of the backup upon completion of each backup job.
3. Backup Process
    a. Daily backups are stored on a hard disk storage device and then duplicated to backup tapes.
    b. Daily backups have a retention period of 14 days; after which time they are overwritten.
    c. Monthly backups are encrypted and they are stored on physical backup tapes.
    d. After successful month-end backups, the tapes are moved from the tape library to a fireproof safe.
    e. Monthly backups are kept in the fireproof safe for a period of 10 years;
    f. Backups are monitored on a daily basis.
    g. Backup logs of all backup and restore operations are stored electronically within the backup software.
    h. Physical log books are kept for all tape media that is moved between the tape library and the fireproof safe. The log includes the following details:
        i. Tape bar code;
        ii. Date of backup;
        iii. Date of relocation;
        iv. Location of backup tape;
        v. Reason for the move;
        vi. Technician name; and,
        vii. Contents of the tape.
4. Backup Failures
    a. In the event of backup failures, the backup software is configured to automatically alert PeHS technicians via an email notification.
        i. PeHS will work with vendor support as needed to resolve the problem.
5. PeHS does not back up individual workstations (desktops and laptops). Users are encouraged to save data to a shared network drive (i.e. R Drive or similar).

CORPORATE POLICY & PROCEDURE

	Policy Name: Data and Application Criticality Analysis
Department: PeHS	Policy Number: H20
Version: 4	Creation Date: 8/1/2011
Revised Date: 11/30/2017	Review Date:
Line of Business: ☒ All	
☐ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health - Transitional Care
Signature: 	
Approved By: Michael von Arx, Chief Operating Officer	Date: 3/29/2018

POLICY STATEMENT

Umpqua Health must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA implementing regulations pertaining to data and application criticality analysis, in accordance with the requirements of 45 CFR 164.308(a)(7)(E). Failure to comply with these regulations may result in such consequences as monetary penalties, imprisonment, and/or loss of license.

PURPOSE

A thorough assessment and understanding of the relative criticality of both data and applications is essential to emergency preparedness in order to effectively protect individually identifiable health information, including Protected Health Information (PHI), during emergencies and during normal business operations. This assessment determines how important the data and applications are to the business, in order to prioritize for data backup, disaster recovery and emergency operations plans.

RESPONSIBILITY

Physician eHealth Services (PeHS)

DEFINITIONS

Protected Health Information (PHI): Any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity (or a business associate of a covered entity), and can be linked to a specific individual.

PROCEDURES

1. Data subject to criticality analysis shall include individually identifiable health information, including PHI.
2. The most critical data and applications shall be given the highest priority in terms of investment and emergency protection preparations; with less critical categories or types

of data and applications receiving proportionately less funding and attention, as appropriate.

3. In conducting data and applications analyses, PeHS shall employ the technical guidance and recommendations of the National Institute of Standards and Technology ("NIST"), or other information technology "best practices," as appropriate.
4. Analyses shall include the following elements:
    a. Location;
    b. Type of data;
    c. Vendor/Software (i.e. GE Centricity EMR);
    d. Hardware / Service (i.e. server names);
    e. Safeguards in place (i.e. user access controls, battery backups, diesel generator, fire suppression);
    f. Vulnerabilities (i.e. loss of PHI equipment and records, closure of facility);
    g. Threats (i.e. natural and man-made disasters);
    h. Likelihood of impact (low, medium, high);
    i. Criticality level (i.e. low, medium, high).
5. Data and application criticality analysis is done as needed, but at least on an annual basis.
6. Documentation of the analysis is stored on a PeHS file server.

CORPORATE POLICY & PROCEDURE

	Policy Name: Outsourced Data Processing and Storage
Department: Physician eHealth Services	Policy Number: IT12
Version: 1	Creation Date: 9/6/2018
Revised Date:	Review Date:

Line of Business: ☒ All

☐ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health - Transitional Care

Signature:

Approved By: Michael von Arx, Chief Operating Officer Date: 9/6/2018

POLICY STATEMENT

Umpqua Health is committed to documenting appropriate processes for protection of outsourced Medicaid data, in accordance with the Coordinated Care Organization (CCO) contract and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PURPOSE

To provide a procedure of accessing Medicaid data stored offsite and/or with an outside vendor, as well as how the data is to be handled by an outside vendor.

RESPONSIBILITY

Physician eHealth Services (PeHS)

DEFINITIONS

Protected Health Information (PHI): Any information about health status, provision of health care, or payment for health care that is created or collected by a covered entity (or a business associate of a covered entity), and can be linked to a specific individual.

Subcontractor: Any entity, facility or organization that has entered into a subcontract with Umpqua Health or with any subcontractor for any portion of the work under the Oregon Health Authority's CCO contract with Umpqua Health Alliance (CCO Contract, Exhibit A, Section 3).

PROCEDURES

Data Processing and Protection

1. Subcontractor can process data only as per instructions from Umpqua Health, in accordance with the CCO contract.
2. Subcontractor is required to use the data only for specific purposes, as defined by the contract with Umpqua Health.
3. Subcontractor must ensure a high level of data protection and data security, based on current industry standards and HIPAA regulations.

	Policy Name: Outsourced Data Processing and Storage
Department: Physician eHealth Services	Policy Number: IT12
Version: 1	Creation Date: 9/6/2018
Revised Date:	Review Date:

4. Subcontractor must have adequate security technology on the infrastructure that is used for data processing (e.g. not just firewalls and virus scanners).
5. Subcontractor's employees may only access data as is appropriate for the type and scope of the task in question. The "need to know" principle applies.
6. Before the introduction of new methods of data processing, particularly new information technology (IT) systems, technical and organizational measures to protect data must be defined and implemented.
7. Data may not be used for advertising or marketing purposes.
8. Data may not be disclosed to unauthorized parties.
9. PeHS may periodically request a copy of subcontractor's organizational IT and data security policies, typically done once per year.

Data Security

1. Data must be safeguarded from unauthorized access and unlawful processing or disclosure, as well as accidental loss, modification or destruction. This applies regardless of whether data is processed electronically or in paper form.
2. Security measures must be based on information-technology "best practices", recommendations of the National Institute for Standards and Technology ("NIST") and any identified risks of data processing.
3. Data should only be stored on designated drives and servers.
4. Data must be stored in secure facilities located within the United States.
5. All servers and computers containing data should be protected by security software and firewalls.
6. Data at-rest (e.g. data in databases, file systems and storage infrastructure) must be protected by strong encryption such as Advanced Encryption Standard (AES) or Rivest-Shamir-Adleman (RSA).
7. Data must be encrypted before being transferred electronically (e.g. HTTPS, TLS, etc.).
8. In the event of a data loss or breach, subcontractor is required to notify Umpqua Health within 60 days from the date of discovery (UH Policy H4 – Notification of Breach).

Accessing Data Located Offsite and/or with an Outside Vendor

1. Subcontractor must provide a secure method of accessing data located on its infrastructure.
2. Subcontractor may not use outdated security protocols (e.g. Secure Sockets Layer (SSL) version 2/3 and early Transport Layer Security (TLS)).
3. Typical methods of remotely accessing data are through a SSL website or via a Virtual Private Network (VPN).
4. Remote access servers should authenticate each user before granting access to sensitive data.

	Policy Name: Outsourced Data Processing and Storage
Department: Physician eHealth Services	Policy Number: IT12
Version: 1	Creation Date: 9/6/2018
Revised Date:	Review Date:

5. Umpqua Health employees may only use PeHS approved computer equipment for connecting to subcontractor systems and accessing data.
6. Umpqua Health employees access to vendor systems is controlled by role based security settings (UH Policy H14 – Authorization, Supervision and Workforce Clearance).

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Assignment and Reassignment
Department: Member Services	Policy Number: MS1
Version: 3	Creation Date: 4/26/2017
Revised Date: 10/16/18, 8/28/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☒ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael von Arx, Chief Operating Officer Date: 1/30/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) is dedicated in ensuring its members have timely and adequate access to primary care providers (PCP). Additionally, UHA is dedicated in ensuring that its network providers have a fair approach to request member reassignment, while taking into consideration barriers, coordination of care, and a timely transition for impacted members.

PURPOSE

The purpose of the policy is to outline the decision making process and necessary steps to assign and reassign a member from a provider.

RESPONSIBILITY

Member Services, Provider Network, Credentialing

DEFINITIONS

Closed PCP: PCPs are closed if any of the following situations are met:

1. Provided communication to UHA that they are no longer accepting new members.
2. PCP has a screening or approval process prior to member assignment.
3. PCP is unable to meet UHA's PN8 - Monitoring Network Availability policy.
4. PCP is closed due to the number of member assignments reaching capacity.
5. To facilitate the building of a new provider's panel, the assignment of 150 members begins upon the completion of the credentialing process. Member Services will contact the PCP to obtain capacity initially and again once the PCP's set capacity is met, giving the provider the opportunity to raise or lower capacity as needed.

FKA: Formerly known as.
Initial Assignment: UHA's internal process to assign a newly enrolled member to a PCP.

Open PCP: PCPs are considered open if all of the situations below are met:

1. Provides care in accordance with Oregon Administrative Rule (OAR) 410-141-3515 (fka 410-141-3220) and UHA's PN8 - Monitoring Network Availability policy.

2. Accepts all members assigned, unless reassignment granted through UHA's MS1 - Member Assignment and Reassignment policy.
3. Patient-Centered Primacy Care Home (PCPCH) attested with the Oregon Health Authority (UHA); Tier 3 or higher with the exception of a new practice/Tax identification number (TIN) that is within the first 1 ½ year of business.
4. Willing to accept new members without prior approval or screening.
5. Provides UHA with the patient capacity that allows for assignment. A PCP will remain open until capacity is met.
    a. Example; provider capacity is 500 with 400 patients/members currently assigned. The provider will remain on an open status until 500 members are assigned.

Patient-Centered Primary Care Home (PCPCH): A health care team or clinic as defined in Oregon Revised Statue (ORS) 414.655, which meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

Primary Care Provider (PCP): An enrolled medical assistance provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified members. PCPs are health professionals who initiate referrals for care outside their scope of practice, consultations, and specialist care, and assure the continuity of medically appropriate member care. PCPs include:

(a) The following provider types: physician, naturopath, nurse practitioner, physician assistant or other health professional licensed or certified in this state, whose clinical practice is in the area of primary care;

(b) A health care team or clinic certified by the Oregon Health Authority (OHA) as a PCPCH as defined in OAR 409-027-0005 and OAR 410-120-0000.

Reassignment: The internal process UHA takes to redistribute members to a new PCP under certain scenarios.

Termination: Process in which a PCP request a member be reassigned from its practice.

PROCEDURES

Initial PCP Member Assignment

1. All UHA members are assigned to an open PCP upon becoming eligible with UHA.
2. Initial assignments are made within the first week of enrollment for all members, including:
    a. Members newly enrolled to UHA.
    b. Members newly re-enrolled to UHA.
    c. Members transferring from fee-for-service or from another Coordinated Care Organization (CCO).

i. UHA will assign a member to a closed PCP if there was a previous relationship and the provider has capacity.
ii. If an incoming member is transferring from fee-for-service or another CCO, UHA will honor and assign the member to their former PCP.
iii. If that PCP is out-of-network, UHA will approve the out-of-network PCP for up to 90 days or until a new open PCP is established and have been able to review the member's treatment plan in accordance with OAR 410-141-3850(5) (fka 410-141-3061(5)).
    1. A separate process in available for members with Special Health Care needs (see Transfer of Care section).

3. For all initial assignments (with the exception noted above in 2.c.i), UHA's Member Service Department will attempt to contact the member and/or family by phone during the first week of enrollment to obtain the member's preferred choice of an open PCP.
4. In the event UHA is unable to contact the member and to prevent a disruption in service, members will be assigned to an open PCP using the following algorithm.
    a. If a member has been enrolled with UHA before:
        i. UHA will look for and assign the member to the open PCP that has a past relationship with a member as defined by the PCP who performed the plurality of visits in the last 24 months, or most recent office visit.
        ii. Open PCP with the same TIN as a mental health provider with whom the member has a current relationship (seen in the last 15 months).
    b. No prior enrollment with UHA:
        i. Closest open PCP office to member's home.
        ii. Open PCP that can accommodate certain member needs (e.g. age, special needs, language, disabilities, other family members assigned etc.

<u>Member Reassignments from a PCP</u>

1. The Member Services Department may have to reassign members to a new PCP.
2. Such common reasons for reassignment include:
    a. Provider chooses to relinquish all of their UHA assigned members.
        i. Provider is no longer contracted.
        ii. Provider leaves and the practice/office closes or does not have another provider who is open to new patients/member assignments.
    b. Member exceeds the standard for travel time of 30 minutes urban/60 minutes rural or the distance of 30 miles urban/60 miles rural.
3. In the event members needs to be reassigned from their PCP, the Member Services Department will follow the process below:
    a. Member Services will contact the members impacted and advise them about the need to reassign them from their current PCP.

i. Members will be given an option to select a new open PCP within the network. Member choice is top priority.

b. In the event a PCP is not selected, UHA will reassigned an open PCP to a member using the following algorithm.
   i. Reassigned to the same practice/TIN, but to a different open PCP within the practice.
      1. Ensures the promotion and continuation of care for members by maintaining the medical record by their previous PCP's clinic. This is especially important in scenarios where a provider moves to a new practice or moves out of the area.
         a. Practice must have capacity and providers who are open to new patient/member assignments.
         b. If the practice has a related TIN (e.g. at a different office location), members may be reassigned to the other location so as long as there is capacity, providers are open to new membership and the member's travel time does not exceed 30 minutes urban/60 minutes rural or 30 miles urban/60 miles rural.
   ii. Open PCP with the same TIN as a mental health provider with whom the member has a current relationship (seen in the last 15 months).
   iii. An open PCP has a past relationship with a member as defined by the PCP who performed the plurality of visits in the last 24 months, or most recent office visit.
   iv. Closest open PCP office to member's home.
   v. Open PCP that can accommodate certain member needs (e.g. age, special needs, language, disabilities, other family members assigned etc.

<u>Request for Member Assignment</u>

1. Members are allowed to select their own PCP or change PCP's at any time.
2. Member choice for PCP assignment is encouraged and, at any time, the member may call UHA to change PCPs. However, to facilitate accurate and convenient member assignments, a provider can request a PCP change on behalf of a member.
   a. The change can be made by phone or by using the PCP Change Request form attached.

<u>Transfer of Care</u>

1. The OHA requires UHA to coordinate care for members with special health care needs who are transferring to or from another CCO. Qualifying members will be allowed to continue receiving treatment from an established non-participating PCP. To accommodate this, transferring members will be exempt from PCP assignment for the

first 90 days of UHA eligibility. These members will be notified in writing of the requirement to choose an in-network PCP within 14 days of enrollment. Once the 90 days has ended, the member will be treated as an initial assignment and assigned to an open PCP the first day following the 90-day transition period.

Request for Member Termination

1. Providers may request a member to be terminated and reassigned to another provider.
2. In the event a provider seeks a member termination, the provider office must contact UHA's Member Services Department for approval prior to termination.
    a. Prior approval is not needed for:
        i. Aggressive, assaultive, and/or disruptive behavioral that is not due to a member's special needs.
        ii. Illegal or fraudulent activities (e.g., illegal conduct on clinic property, tampering or forging prescriptions or medical records).
        iii. Providers are still expected to notify UHA's Member Services Department about the incident and termination, in which UHA may ask for additional documentation such as medical records and police reports.
3. Depending on the nature for termination, UHA expects providers to consider, on an individual basis, whether termination would be appropriate for the member.
4. If possible and safe to do so, providers should attempt to mitigate any behavior in order to maintain the relationship. Such activities may include:
    a. Counseling or educating the member on the concern.
    b. Contacting UHA for care coordination needs.
    c. Communication with the member that any future events will result in termination.
        i. Example: Speaking to the member by phone, during an appointment, and/or by letter. Documentation of the discussion should be noted in the member's medical record.
5. UHA will authorize a request for termination for frequent missed appointment only if the following has occurred:
    a. Member was given a copy of the provider's policy at intake.
    b. The policy allows no less than four missed appointments over a six-month period.
    c. The provider has made documented attempts to remind the member of upcoming appointments.
    d. The provider has attempted to reduce barriers (e.g., transportation needs).
    e. The provider has previously reached out to UHA's Member Services Department regarding the member, requesting a care coordination referral to assist with member engagement.
6. UHA will not approve a termination request for the following reasons:
    a. Because of a physical, intellectual, developmental, or mental disability.
    b. Because of an adverse change in the member's health.

c. Excessive or lack of utilization.
d. Member requests a second opinion.
e. Member requests a hearing.
f. Member exercises his or her option to make decisions regarding their medical care.
g. Member utilizes too much of clinic's staff time and/or resources.
h. Member has an unpaid account.
i. Member exercises any of their rights under OAR 410-141-3320.

7. Upon receipt of the request, UHA's Member Services Department will render a decision within five business days on whether the request has been approved.
8. Member Services will also inform the Provider Network Department of any potential termination requests that do not align with this policy.
    a. The Provider Network Department will then contact the provider for remediation strategies.

Coordination of Termination

1. Once a request for termination has been approved, providers are expected to assist in the coordination of care process.
2. Upon approval of termination, the provider office must inform the member by mail of the termination within two business days of approval.
3. Content of the letter to the member should include:
    a. Reason for termination, if appropriate.
    b. Timeline for termination.
        i. If possible and safe to do so, providers should attempt to provide a 30-day or more transition period.
            1. In certain situations, a longer transition may be warranted if it is feasible and safe to do so.
            2. Shorter transitions may be necessary specifically in situations where safety is a concern (e.g., immediate reassignment).
        ii. Provider availability during the transition, such as being willing to see the member during the transition timeframe for routine and/or urgent appointments.
    c. Prescriptions.
        i. If member is currently using prescription prescribed by the provider, a dialogue of future refills (if applicable) is needed during the transition.
    d. Referrals, labs, and/or imaging studies follow up.
        i. If member currently has open referrals, labs, imaging studies, etc. that were referred by the provider, the letter must discuss the process for follow up of these services during the transition period.
    e. Name, address, and phone number for new provider (if known).

f. Language that member's medical records will be available for ten years.

4. If there are any barriers during the transition process, providers should contact UHA's Member Services and/or Care Coordination team for assistance.

Monitoring for Compliance

1. UHA will routinely monitor provider compliance with this policy. Potential problematic activities include:
    a. Failure to timely schedule an appointment with new members.
    b. Not responding to UHA's access to care surveys.
    c. Using screening or applications processes on members.
    d. Providers who are frequently requesting termination.
    e. Inability to address barriers to care.
    f. Lack of coordination during the termination process.
2. In the event a provider is found to be engaging in practices incongruent with this policy, administration sanctions may be imposed, including:
    a. Corrective action plans.
    b. Suspension of new member assignment.
    c. Reassignment of current members.
    d. Termination of provider agreement.

Weekly Assignment Roster

1. To assist UHA's PCPs with identifying their newly assigned members and to establish care, a weekly list is sent.
2. The member list is delivered weekly on the last business day after assignment. Or, on the next business day if Friday was a holiday.
    a. Member Services sends the list to PCP's via secure email.
    b. Sign up or unsubscribe to the weekly PCP list by emailing UHAMemberServices@UmpquaHealth.com.

Quarterly Member Reconciliation Process

1. To ensure that UHA members are accurately assigned, UHA will institute a quarterly reconciliation process.

a. On the first business day of the quarter, a list of all assigned members will be sent to all PCP's.
b. The PCP's office has 15 calendar days to verify the accuracy of the assignment list and may add or remove members as needed.
c. Any response received after the 15th day will be disregarded.
d. No response will be interpreted as an admission that the list sent was accurate with no changes necessary.

2. On the 16th day, UHA will reconcile the updated lists received from each office.

a. For any unassigned, removed, or disputed members (e.g. multiple offices declare assignment), UHA will use the algorithm for assignment described above in this policy.

UMPQUA HEALTH

You can have this in large print, another language, or any way that works for you. You can have a language interpreter if you need one. Please call us at 541-229-4UHA (541-229-4842).

Primary Care Physician Change Request Form

To Physician: With the patient's consent, please fill out the entire form, ask your patient or their representative to sign it, and send it to UHA. We will not process incomplete or unsigned forms. Incomplete forms will be returned (if possible).Assignment requests must be for PCPs in UHA's network.

Important

- Any prior approvals may no longer be valid with the new PCP.
- If the member goes into the hospital before the change takes effect, the member will remain with the existing PCP until the episode of care is complete.
- If a mother requests a PCP assignment for her newborn, we will process the request or change after the baby has an Oregon Health ID card.
- Most changes will take effect the date UHA receives this form.

Option for member to self-select PCP by phone

You also can change to a different PCP by calling Umpqua Health Alliance Member Services at 541-229-4842. We are open Monday – Friday 8:00 am – 5:00 pm.

Option for member to select PCP in physician's office

Please fill out all sections highlighted in BLUE

Patient name: _____ Date of birth: _____

UHA member ID: _____ Phone number: _____

Mailing Address: _____

Signature: _____ Date: _____

Member or authorized representative

UMPQUA HEALTH

Current PCP (if any)

PCP Name: _____ Group/location:_____

Reason for change from assigned PCP – Choose all that apply. **Select** at least one.

☐New member - first-time selection

☐Already patient with requested PCP

☐ADA Accessibility

☐Availability to get appointment, access to care

☐Member preference

☐Wait time in provider office

☐ Requested PCP already sees family member

☐ Language / Communication barriers / Cultural Considerations

☐Member moved

☐PCP hours didn't fit member need

☐Established relationship w/another

☐Quality of care

☐Provider request to disenroll member

☐Provider left network

☐ Provider Location

☐Other:_____

This section is for Providers Office only

New PCP

Requesting PCP Name: _____

NPI: _____ Tax ID: _____

Address: _____

Preparer name: _____ Phone number: _____

Preparer signature: _____ Date: _____

Submit the form

Please submit the completed form to UHA by fax at 541-677-6038, or by mail to Umpqua Health Alliance 500 SE Cass St, Suite 101, Roseburg OR 97470.

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Rights
Department: Member Services	Policy Number: MS3
Version: 4	Creation Date: 5/31/2017
Revised Date: 6/3/19, 1/9/20	Review Date: 5/22/19

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael von Arx, Chief Operating Officer Date: 1/10/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) is dedicated to providing the best possible care and experience for its members. Therefore, UHA, along with its subcontractors, will comply with all Federal and State laws regarding member rights as described in the UHA Member Handbook as well as the Oregon Administrative Rules (OAR) 410-141-3320, 410-141-3920 through 410-141-3960, 42 Code of Federal Regulation (CFR) § 438.100 and Coordinated Care Organization (CCO) Contract Exhibit B, Part 2, Section 5(d)(1) and Exhibit B, Part 3.

PURPOSE

To ensure that UHA members, employees and providers are aware of the health plan members' rights under Medicaid law.

RESPONSIBILITY

Member Services

DEFINITIONS

Care team: The group of providers, community members, and/or volunteers assigned to work with the member.

External personnel: Individual contractors, subcontractors, network providers, agents, first tier, downstream, and related entities, and their workforce.

Internal personnel: All Umpqua Health employees, providers, volunteers.

Member: A Medicaid beneficiary who is currently enrolled in Umpqua Health Alliance or who may potentially enroll. For the purposes of OAR 410-141-3920 through 410-141-3965, references to a "member" include any individual eligible for NEMT services under the policy.

PROCEDURES

General

	Policy Name: Member Rights
Department: Member Services	Policy Number: MS3
Version: 4	Creation Date: 5/31/2017
Revised Date: 6/3/19, 1/9/20	Review Date: 5/22/19

1. Members are informed in writing of their rights through the Member Handbook.
    a. Provided to members within 14 days upon enrollment and re-enrollment.
    b. Available upon request at no charge to the member and is mailed within five (5) business days.
2. In the event an individual feels that one of their rights have been violated, the member may contact UHA's Member Services Department, in which a grievance will be filed.
    a. UHA's Clinical Engagement Department periodically review grievances pertaining to member rights.
3. In accordance with 42 Code of Federal Regulation (CFR) § 438.100(a)(2), internal and external personnel are required to comply with any applicable Federal and State laws that pertain to enrollee rights, and ensure they observe and protect those rights. Failure to do so will result in corrective actions in accordance with policy CO19 – Disciplinary Process for Compliance Infractions, up to and including termination of employment or contract.
4. UHA members are entitled to the following rights as outlined in OAR 410-141-3320 and UHA's CCO Contract Exhibit B, Part 3:
    a. To be treated with dignity and respect with due consideration for his or her privacy;
    b. To be treated by participating providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs;
    c. To choose a Primary Care Provider (PCP) or service site, and to change those choices as permitted by UHA's administrative policies;
        i. For a member in a service area serviced by only one Prepaid Health Plan (PHP), any limitation UHA imposes on his or her freedom to change between PCPs or to obtain services from non-participating providers if the service or type of provider is not available with the UHA's provider network may be no more restrictive than the limitation on disenrollment under CCO contract Exhibit B, Part 3(6)(b).
    d. To refer oneself directly to behavioral health or family planning services without getting a referral from a PCP or other participating provider;
    e. To have a friend, family member, or advocate present during appointments and other times as needed within clinical guidelines;
    f. To be actively involved in the development of their treatment plan;
    g. To be given information about their condition and covered and non-covered services to allow an informed decision about proposed treatments, including alternative treatments;

h. To consent to treatment or refuse services (i.e. medical, surgical, substance use disorders, and/or mental health treatment) and be told the consequences of that decision, except for court ordered services;
i. To execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 -- Patient Self-Determination Act;
j. To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
k. To have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;
l. Have in place a mechanism to help members and potential members understand the requirements and benefits of UHA's plan and develop and provide written information materials and educational programs consistent with the requirements of OAR 410-141-3280 and 410-141-3300;
m. To receive culturally and linguistically appropriate services and supports, in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;
n. To make certified or Qualified Health Care Interpreter Services available free of charge to each potential member and member. This applies to all non-English languages, not just those that Oregon Health Authority (OHA) identifies as prevalent. UHA shall notify its members and potential members that oral interpretation is also available free of charge for any language and that written information is available in prevalent non-English languages in service area(s) as specified in 42 CFR § 438.10(c)(3). UHA shall notify its members how to access oral interpretation and written translation services;
o. To receive oversight, care coordination and transition and planning management from UHA to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;
p. To receive necessary and reasonable services to diagnose the presenting condition;
q. To receive integrated person centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;
r. To have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

s. To receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, and advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
t. To obtain covered preventive services;
u. To have access to urgent and emergency services 24 hours a day, 7 days a week without prior authorization;
v. To receive a referral to specialty providers for medically appropriate covered coordinated care services, in the manner provided in the CCO's referral policy;
w. To have a clinical record maintained which documents conditions, services received, and referrals made;
x. To have access to one's own clinical record, unless restricted by ORS 179.505 or other applicable law and to request that the records be amended or corrected as specified in 45 CFR Part 164;
y. To transfer of a copy of the clinical record to another provider;
z. To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;
aa. To receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or state regulations;
bb. To be able to make a complaint or appeal with UHA and receive a response;
cc. To request a contested case hearing;
dd. To receive a notice of an appointment cancellation in a timely manner;
ee. Ensure members are aware that a second opinion is available from a qualified health care professional within the provider network, or that UHA will arrange for members to obtain a qualified health care professional from outside the provider network, at no cost to the members;
ff. Ensure members are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, that a member has a right to report a complaint of discrimination by contacting UHA, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR);
gg. Provide notice to members of UHA's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance

with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A;

hh. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270;

ii. Allow each member to choose his or her health professional from available participating providers and facilities to the extent possible and appropriate. For a member in a service area serviced by only one Prepaid Health Plan (PHP), any limitation UHA imposes on his or her freedom to change between PCPs or to obtain services from non-participating providers if the service or type of provider is not available with the UHA's provider network may be no more restrictive than the limitation on disenrollment under CCO contract Exhibit B, Part 3, Section 6.b;

jj. Require, and cause its participating providers to require, that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand;

kk. Furnish to each of its members the information specified in 42 CFR § 438.10(f)(2)-(3), and 42 CFR § 438.10(g), if applicable, as specified in the CFR within 30 days after the UHA received notice of the member's enrollment from OHA or for members who are Fully Dual Eligible, within the time period required by Medicare. UHA shall notify all members of their right to request and obtain the information described in this section at least once a year;

ll. To ensure members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliations specified in federal regulations on the use of restraints and seclusion;

mm. Ensure, and cause its participating providers to ensure, that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the UHA, its staff, subcontractors, participating providers or OHA, treat the member. UHA shall not discriminate in any way against members when those members exercise their rights under the OHP;

nn. Ensure that any cost sharing authorized under the CCO contract for members is in accordance with 42 CFR § 447.50 through 42 CFR § 447.60 and with the General Rules.

oo. Notify members of their responsibility for paying a co-payment for some services, as specified in OAR 410-120-1230; and

pp. UHA may use electronic methods of communications with members, at their request, to provide member information if:

a. The recipient has requested or approved electronic transmittal;
b. The identical information is available in written form upon request;

c. The information does not constitute a direct member notice related to an adverse Action or any portion of the grievance, appeals, contested case hearings or any other member rights or member protection process;
d. Language and alternative format accommodations are available; and
e. All HIPAA requirements are satisfied with respect to personal health information.

Non-Emergent Medical Transportation (NEMT)

1. UHA informs members of their rights through the UHA Rider's Guide.
    a. Provided to members within 14 days upon enrollment and re-enrollment.
    b. Available upon request at no charge to the member and is mailed within five (5) business days.
2. Have access to a toll-free call center to request rides.
3. To not be billed for transport to or from covered medical services, even if UHA or its NEMT subcontractor denied reimbursement for the transportation services.
4. To schedule transportation within the timelines outlined in MS7 - Non-Emergent Medical Transportation.
5. Member pick up:
    a. Not required to enter a transportation vehicle more than 15 minutes prior to the scheduled pick up time.
    b. To not arrive to an appointment more than 15 minutes prior to the office or other facility opening for business unless requested by the member, the member's guardian, parent, or representative.
    c. To not be picked up after an appointment more than 15 minutes after the office or facility closes for business, unless the appointment is not reasonably expected to end within 15 minutes after closing, or as requested by the member, or as applicable, the member's guardian, parent, or representative.
6. Transportation to or from a source of covered service or health-related service, that does not involve a sudden, unexpected occurrence which creates a medical crisis requiring emergency medical services as defined in OAR 410-120-0000 and requiring immediate transportation to a site, usually a hospital, where appropriate emergency medical care is available.
7. Members have passenger rights and responsibilities as set forth in 42 CFR § 438.100, and as set forth in OARs 410-141-3920 through 410-141-3960, and other State and Federal administrative statutes and rules relating to the rights and responsibilities of Medicaid recipients such as the right to file a grievance and request an appeal or reconsideration (CE01 – Grievances and CE20 – Appeals and Hearings). The grievance and appeal processes and rights specified in OAR 410-141-3835 through 410-141-3915 are available

with respect to NEMT services with the modifications outlined in MS7 - Non-Emergent Medical Transportation.

8. Comfort and safety in all vehicles used for NEMT services and must meet the following requirements:
    a. The interior of the vehicle will be clean and free from any debris impeding a member's ability to ride comfortable;
    b. Smoking, aerosolizing, or vaporizing of inhalants is prohibited in the vehicle at all times in accordance with Oregon Revised Statute (ORS) 433.835 to 433.990 and OAR 333-015-0025 to 333-015-0090; and
    c. In compliance with all applicable local, State and Federal transportation laws regarding vehicle and passenger safety standards and comfort. The vehicles will include, without limitation, to the following safety equipment:
        i. Safety belts for all passengers if the vehicle is legally required to provide safety belts;
        ii. First aid kit;
        iii. Fire extinguisher;
        iv. Roadside reflective or warning devices;
        v. Flashlight;
        vi. Tire traction devices when appropriate;
        vii. Disposable gloves; and
        viii. All equipment necessary to securely transport members using wheelchairs or stretchers in accordance with the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Action of 1973, and ORS 659A.103.
    d. The vehicle to be in good operating condition and to include, but not limited to, the following equipment:
        i. Side and rearview mirrors;
        ii. Horn;
        iii. Heating, air conditioning, and ventilation systems; and
        iv. Working turn signals, headlights, taillights, and windshield wipers.
    e. Drivers:
        i. Who have passed a criminal background check in accordance with ORS 181A.195 and 181A.200, and OAR Chapter 257, Division 10;
        ii. Who have a valid driver's license. The license must be the class of license with any required endorsements that permits the driver to legally operate the vehicle for which they are hired to drive pursuant to ORS Chapter 807 and OAR Chapter 735, Division 062, or the applicable statutes of other states;

iii. Who are not included on the exclusion list maintained by the Office of the Inspector General; and
iv. Authorized to provide NEMT services that have received training on their job duties and responsibilities as outlined in OAR 410-141-3925(5)(a)-(f).

f. Emergency Medical Technicians (EMT) hired as an NEMT driver to be licensed under OAR Chapter 33, Division 265.
g. To be provided NEMT services outside of UHA's service area under any of the following circumstances:
    i. The member is receiving covered services that are not available, in accordance with OAR 410-141-3515, in UHA's services area;
    ii. The member is receiving covered services outside of Oregon, but the location is contiguous to UHA's services area and no more than 75 miles from the Oregon border;
    iii. The member is receiving in-patient services at a facility outside UHA's services are due to unavailability within UHA's service area and the member requires additional covered services within the service area where the inpatient service facility is located; and
    iv. The member is receiving covered services outside the State of Oregon because the required covered service is not available within Oregon.
h. Attendants:
    i. For children 12 years of age and under who are eligible for NEMT services to and from OHP- covered medical services and members with special physical or developmental needs regardless of age.
        1. Parents or guardians must provide an attendant to accompany these members while traveling to and from covered services and other purposes authorized by UHA in accordance with OAR 410-141-3930(2) except when:
            i. The driver is a Department of Human Services volunteer or employee or an OHA employee;
            ii. The member requires secured transport pursuant to OAR 410-141-3940 (secured transports); or
            iii. An ambulance provider transports the member for non-emergent services, and UHA reimburses the ambulance provider at the ambulance transport rate per CCO Contract.
        2. An attendant may be the member's mother, father, stepmother, stepfather, grandparent, or guardian. The attendant must also be any adult 18 years or older authorized by the member's parent or guardian.

3. UHA has the right to require the member's parent or guardian to provide written authorization for an attendant other than the parent or guardian to accompany the member.
4. The attendant must accompany the member from the pick-up location to the destination and the return trip.
5. The member's parent, guardian, or adult caregiver shall provide an install safety seats as required by ORS 811.210-811.225. An NEMT driver may not transport a member if a parent or guardian fails to provide a safety seat that complies with State law.

ii. For NEMT services for the involuntary transport of members who are in danger of harming themselves or others, secured transport may be used in accordance with OAR 410-141-3940.
1. One additional attendant may accompany the member at no additional charge when medically appropriate, such as to administer medications in-route or to satisfy legal requirements including, but not limited to, when a parent, legal guardian, or escort is required during transport.

g. Member service modifications and rights:
i. UHA may modify NEMT services when the member:
1. Threatens harm to the driver or others in the vehicle;
2. Presents a direct threat to the driver or others in the vehicle;
3. Engages in behaviors or circumstances that place the driver or others in the vehicle at risk of harm;
4. Engages in behavior that, in the UHA's judgement, causes local medical providers or facilities to refuse to provide further services without modifying NEMT services;
5. Frequently does not show up for scheduled rides; or
6. Frequently cancels the ride on the day of the scheduled ride time.

ii. A member may request modification of NEMT services when the NEMT drive:
1. Threatens to harm the member or others in the vehicle;
2. Drives or engages in other behavior that places the member or others in the vehicle at risk or harm; or
3. Presents a direct threat to the member or others in the vehicle.

iii. Reasonable modifications include:
1. Use of specific transportation provider;
2. Travel with an attendant;
3. Use of public transportation where available;

4. Drive or locate someone to drive the member and receive mileage reimbursement; and
5. Confirm the ride with the NEMT provider on the day of or the day before the scheduled ride.

iv. The following may also cause modifications to your ride services:
1. A member has a health condition that is a direct threat to the driver or others in the vehicle.
2. A member threatens harm to the driver or others in the vehicle.
3. A member engages in behavior or creates circumstances that puts the driver or others in the vehicle at risk of harm.

h. Members have the right to be advised at the time of request for NEMT services of the need for accommodation which will be followed by written confirmation to the member, the member's care coordinator, and any requesting provider. Before modifying services, the NEMT provider, a UHA representative, and the member will:
i. Communicate about the reason for imposing a modification;
ii. Explore options that are appropriate to the member's needs; and
iii. Address health and safety concerns.
iv. Communications listed in 8(h)(i)-(iii) of this policy may include:
1. The member's care team, including any care coordinator, at the request or upon approval of the member or UHA; and
2. Any other individual of the member's choosing.

i. Member reimbursed mileage, meals and lodging:
i. The member must return any documentation UHA requires before receiving reimbursement.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A

CORPORATE POLICY & PROCEDURE

	Policy Name: Written Notices to Members
Department: Member Services	Policy Number: MS4
Version: 5	Creation Date: 6/5/2017
Revised Date: 6/26/19, 7/18/19, 1/15/20,1/28/20	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 3/11/2020

POLICY STATEMENT

To ensure the best quality of services to members, Umpqua Health Alliance (UHA) shall develop and provide written informational materials and educational programs as described in Oregon Administrative Rule (OAR) 410-141-3580, OAR 410-141-3585, and the Coordinated Care Organization (CCO) Contract with the Oregon Health Authority (OHA).

PURPOSE

To ensure that UHA's Member Services Department provides the required written materials within the contract requirements.

DEFINITIONS

Alternative Formats: Means of communication in English and non-English languages, such as large print, Braille, audiotape, oral presentation, and/or electronic format in accordance with Title II of the American with Disabilities Act and Title VI of the Civil Rights Act.

Correction of Deficient Documents: To resolve any disagreements in those instances when Oregon Health Authority (OHA) disapproves of reports, policies and procedures, handbooks, materials, and any other documents required to be provided to OHA or other state or federal agency under this contract for review and approval. UHA shall, unless expressly provided otherwise in this contract, follow the process set forth per the contract.

Limited English Proficiency (LEP): A person who is not fluent in the English language.

Member: A Medicaid beneficiary who is currently enrolled in UHA or who may potentially enroll.

Notice of Privacy Practices (NPP): A notice that describes how medical information about the member may be used and disclosed and how the member can get access to this information.

RESPONSIBILITY

	Policy Name: Written Notices to Members
Department: Member Services	Policy Number: MS4
Version: 5	Creation Date: 6/5/2017
Revised Date: 6/26/19, 7/18/19, 1/15/20, 1/28/20	Review Date:

Member Services

PROCEDURES

UHA shall also notify all members of their right to request and obtain the information described in this section at least annually. These materials and programs shall be in a manner and format that may be easily understood and tailored to the backgrounds and special needs of members and potential members.

Written Materials to Members

1. All written materials for members must:
    a. Use easily understood language and format. The readability and reading levels are assessed using the Microsoft Word function the provides the Flesch-Kincaid level and ease scores. All documents are at or below a sixth-grade reading level.
    b. Use a font size no smaller than 12 point.
    c. Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency (LEP).
    d. Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including:
        i. Written translation;
        ii. Oral interpretation;
        iii. The told-free and TTY/TDY customer service number; and
        iv. Availability of materials in alternative formats.
    e. UHA provides the members of this information by mailing a printed copy of the information to the member's mailing address.
    f. Members are informed that the information is available in paper form without charge upon request and provided within five (5) business days.

Member Handbook and Member ID Card

1. All new and re-enrolling UHA members shall be mailed a Member ID card and Member Handbook that contains all required information as outlined in the OHA Coordinated Care Organization (CCO) Contract with UHA. This shall be done within 14 days of eligibility information confirmed by the OHA initial 834 listing with UHA as consistent with Exhibit B, Part 3, Section 4 of the OHA CCO Contract.
    a. If requested by member, UHA will deliver the Member Handbook electronically after receiving the member's agreement to receive information electronically. Provide the information by any other method that can reasonably be expected to result in the member receiving that information.

b. UHA shall review the Member Handbook annually and revise it as needed to stay current with all requirements.
    i. UHA shall notify all existing members of each revision and its location on UHA's website.
    ii. UHA will mail a member a printed copy of the handbook within 5 days of the member's request.
    iii. Alternate formats of UHA's Member Handbook are available to new, potential and re-enrolling members (MS5 – Requests for Interpreter or Alternative Format).

<u>Notices to Members, Timeframes & Correction of Deficient Documents</u>

1. UHA shall provide written notice to affected members of any material change pertaining to program, policies, and procedures that are reasonably likely to impact the affected member's ability to access care or services from UHA's participating providers.
    a. Such notices shall be provided at least 30 days prior to the intended effective date of those changes, or as soon as possible if the participating provider(s) has not given UHA sufficient notification to meet the 30-day notice requirement.
        i. But in no event shall the material changes take effect, and the applicable materials shall not be distributed or otherwise made available to members or other third-parties, until after UHA has received approval of such changes from OHA's Materials Manager.
    b. In the event that the contractor fails to comply with OHA's directive to remedy the document as directed by OHA or upon resubmission to OHA for re-review and approval OHA again determines the document fails to comply with the standards for approval, OHA shall have the right to exercise all of its rights and remedies under Exhibit B, Part 9.
2. Alternate formats of UHA's written materials are available to members upon request (MS5 – Requests for Interpreter or Alternative Format).
    a. Requests for alternate formats will be further tracked in the Requests for Alternate Format Materials Log (see UHA policy MS5- Requests for Interpreter or Alternative Format).
3. Member requests for written materials are completed and mailed out the same day or by Friday of the current week.
4. UHA may use electronic communications to provide member information only if:
    a. The member has requested or approved electronic transmittal;
    b. The identical information is available in written form upon request;
    c. The information does not constitute direct member notice related to an adverse action or any portion of the grievance, appeals, contested case hearings or any other member rights or member protection process;

d. Language and alternative format accommodations are available; and
e. All Health Insurance Portability and Accountability Act (HIPAA) requirements are satisfied with respect to personal health information.

5. Mail Log sheets will be used to track the mailing or postmark dates to ensure compliance.
6. UHA will send out an annual mailing to all current eligible members notifying them of the on-line location to the Provider Directory and Member Handbook. Members will also be informed how they can request a copy be sent to them if they choose. UHA will also inform the member of their right to request and obtain a copy of UHA's NPP.
7. In regards to written informational materials provided to member and potential members, UHA shall:
    a. Not distribute any marketing materials without first obtaining OHA's approval.
        i. UHA shall provide to OHA via Administrative Notice to OHA's Materials Manager for review and approval.
        ii. OHA's Materials Manager shall provide written notice, via Administrative Notice to UHA's Contract Administrator, of approval or disapproval of such submitted materials within 30 days (or within five (5) business days, or shorter if required under the circumstances) of OHA's receipt of such materials.
            1. Should OHA disapprove of UHA's informational and educational materials, UHA remedy the deficiencies in such materials.
            2. All deficiencies must be corrected within 60 days, or when a deadline for distribution to members or third-parties is required under the CCO contract, such deficiencies must be corrected by the date identified by OHA in its administrative notice of disapproval or, if no date is identified, with enough time for OHA to review and approve of such materials in order for UHA to meet the applicable deadline.
    b. Distribute the materials statewide.
    c. Not seek to influence enrollment in conjunction with the sale or offering any private insurance.
    d. Not directly or indirectly, engage in door-to-door, telephone, e-mail, texting, or other call-call marketing activities.
    e. Ensure that a potential member can make his or her own decision as to whether or not to enroll.
    f. Ensure marketing materials are accurate and do not mislead, confuse or defraud the beneficiaries or OHA.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Member Services	N/A	N/A	N/A	N/A

CORPORATE POLICY & PROCEDURE

	Policy Name: Requests for Interpreter or Alternative Format
Department: Member Services	Policy Number: MS5
Version: 5	Creation Date: 6/5/2017
Revised Date: 4/16/19, 6/17/19, 11/25/19, 1/28/20	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 3/11/2020

POLICY STATEMENT

Umpqua Health Alliance (UHA) and its subcontractors shall ensure members and potential members understand that Certified or Qualified Healthcare Interpreter Services and alternative formats of written and electronic UHA materials are available to them. Thus appropriately tailoring communications to comply with modern accessibility standards as required under the Oregon Health Authority's (OHA) Coordinated Care Organization (CCO) Contract, 42 Code of Federal Regulation (CFR) § 438.10, Section 508 Guidelines, Rehabilitation Act Section 504, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor version.

PURPOSE

The purpose of this policy is to ensure that all members and potential members have access to available communications, outreach, and services in alternative formats, as well as languages, that meet members and potential members needs to create and to ensure health equity for all its members as required by Federal and State laws, as well as, the OHA CCO Contract.

RESPONSIBILITY

Member Services

DEFINITIONS

Alternative Formats: Means of communication in English and non-English languages, such as large print, Braille, audiotape, oral presentation, and/or electronic format in accordance with Title II of the American with Disabilities Act and Title VI of the Civil Rights Act.

Certified or Qualified Health Care Interpreter (HCI): UHA contracts with Certified or Qualified HCI services that provide Health Insurance Portability and Accountability Act (HIPAA) compliant HCI services.

Coordinated Care Organization (CCO): A group of all types of health care providers who work together for people on Oregon Health Plan (OHP) in each county of Oregon.

	Policy Name: Requests for Interpreter or Alternative Format
Department: Member Services	Policy Number: MS5
Version: 5	Creation Date: 6/5/2017
Revised Date: 4/16/19, 6/17/19, 11/25/19, 1/28/20	Review Date:

Health Equity: When members are able to reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other social determined circumstances.

Limited English Proficiency (LEP): Members or potential members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Oregon Health Plan (OHP): A program that pays for the healthcare of low-income Oregonians.

Readily Accessible: Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG)2.0 AA and successor versions.

SOP: Standard operating procedure.

Special Needs: Members are visually limited or have limited reading proficiency.

Subcontractor: Any participating provider or any other individual, entity, facility, or organization that has entered into a subcontract with UHA or with any subcontractor for any portion of the work under the CCO contract.

Video Remote Interpreting (VRI): Interpreting service done through video phone calls to provide sign language or spoken language interpretation.

PROCEDURES

1. Members are informed at enrollment, or when seeking to enroll, that they may seek linguistically appropriate services and receive assistance in obtaining a Certified or Qualified HCI (including a telephonic oral interpreter and American Sign Language), use of bilingual UHA personnel, if available, auxiliary aids, or translation of notices in languages other than English, including alternative formats, including Braille, of UHA's written materials free of charge by doing the following actions:
    a. Make a request by phone. Members and potential members may call UHA's Member Services at 541-229-4842 / TTY 541-440-6304.
    b. Make a request in person either through UHA's Member Services or through the member's provider.
    c. Make a request through any other reasonable methods, such as but not limited to, using the patient portal to communicate needs.

	Policy Name: Requests for Interpreter or Alternative Format
Department: Member Services	Policy Number: MS5
Version: 5	Creation Date: 6/5/2017
Revised Date: 4/16/19, 6/17/19, 11/25/19, 1/28/20	Review Date:

2. When members request written materials in a language that needs translated, those materials can be read to the member with a translator over the phone or in person if the information is needed prior to the written translation services being completed (see SOP-MS5-1 – Interpreter Alternative Format Process and SOP-MS5-2 – Written Documentation Translation Services
    a. UHA does not have any prevalent languages in its service area, however all Member Services materials are currently translated to Spanish and are available to be given to a member upon request.
    b. The Member Handbook and Provider Directory, in English and Spanish, are made available on the UHA website for UHA members and contracted providers.
    c. UHA strives to make its written member material available through its website so that it is readily accessible to its members, including establishing audio versions of its material to be effective in 2020.
    d. At time of enrollment into UHA, Member Services will filter out the "language" criteria provided to it by the 834 file and mail Spanish materials to that member.
    e. All written materials for members will use easily understood language and format at or below a sixth-grade reading level using the Flesch-Kincaid scores, use a font size no smaller than 12 point, be available in alternative formats and through provision of auxiliary aids and Certified or Qualified HCI services that takes into consideration the special needs of members with disabilities or limited English proficiency (LEP). It will also include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and Certified or Qualified HCI services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.
3. When a current UHA member requests visual interpretation, Member Services will follow the documented departmental step-by-step process for VRI services. This service will be provided in the format of a tablet that is set up with UHA's Certified or Qualified HCI service provider (see SOP- MS5-1 – Interpreter Alternative Format Process). Members can obtain this service by the following actions:
    a. Make a request by calling Member Services at 541-229-4842 / TTY 541-440-6304.
    b. Make a request through Case Management when a Case Manager is involved.
    c. When in a provider's office.
        i. If the provider does not have an interpreter service of their own, they can call Member Services or Case Management to request the tablet be brought to them for the member's next appointment.
    d. A member can make a request in person by coming to the Member Services office during operating hours.

e. Member Services will keep track of who checks out the tablet and who uses the tablet utilizing the Tablet Sign-Up Sheet (see sample below).

4. Member Services staff will confirm a request for alternate format or language and the item requested.
    i. Member Services staff will track all requests utilizing the Requests for Alternate Format Materials Log (see sample below).

Sample Requests for Alternate Format using the VRI Tablet

Date	Time Out	Time In	CM/ PR Name	Provider	Member ID	Member Name	Language	Dept. to Bill	Suite 101 - Out	Suite 101 - In
5/20/19	2:20PM	5:00PM	John	Dr. ABCD	AB12345C	Jane Doe	Spanish	MS	Andrea	Tena

Sample Requests for Alternate Format Materials Log

Date of Request	Member Service Staff Who Received Request	Member ID Number	Item(s) Requested	Format Requested	Language Requested	Date Item Sent	Method Used to Provide Materials	Email Address Material(s) Sent to…

Reporting of Language Access and Interpreter Services

1. UHA will use the Language Access Report template located on the CCO Contract Forms website to collect and report language access and interpreter services to OHA.
2. UHA will submit the reported language access data to OHA quarterly with monthly detail via Administrative Notice on the third Monday of the months January, April, July and October.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
Member Services	N/A	N/A	N/A	N/A

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Handbook
Department: Member Services	Policy Number: MS9
Version: 1	Creation Date: 6/26/2019
Revised Date:	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 7/3/2019

POLICY STATEMENT

To ensure Umpqua Health Alliance (UHA) maintains an accurate and current version of its Member Handbook. The handbook must meet the requirements specified in Oregon Health Authority's (OHA) Member Communication Requirements which is consistent with the requirements of 42 CFR 438.10(g) and meets the requirement in the Coordinated Care Organization (CCO) Contract Exhibit B, Part 3, Section 4(b).

PURPOSE

To ensure that UHA's members are provided with a Member Handbook that contains the appropriate content and satisfies the requirements of OAR 410-141-3300.

RESPONSIBILITY

Member Services Department

DEFINITIONS

None

PROCEDURES

1. UHA's Member Service Department is responsible for maintaining a Member Handbook with content to educate members on:
    a. How to report suspected fraud, waste and abuse;
    b. How to maintain optimal health status including tobacco cessation information;
    c. The basic features of managed care;
    d. UHA's responsibilities for the coordination of member care;
    e. Member rights and responsibilities;

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A

f. The service area covered by UHA;
g. Communication and language assistance (including a toll-free telephone number);
h. Confidentiality;
i. The requirement for UHA to provide its members access to covered services (including after hours, urgent, emergency care, and crises);
j. How and where to access covered benefits, including how transportation is provided;
k. The process of selecting or changing the member's primary care provider.
l. The process of obtaining second opinions;
m. How to exercise an Advance Directive and Declaration of Mental Health Treatment;
n. The member's right to file grievances and appeals, the requirements, timeframes, and availability of assistance for filing, and the right to request a fair hearing;
o. The location of the Provider Directory; and
p. Any other content required by the State.

2. The handbook is reviewed annually in the first quarter of the year for accuracy. Any internal or regulatory changes are added.
3. The handbook incorporates the elements included in the Appendix J - Review Tool for CCO Informational Materials and Member Education.
4. OHA's approval of the handbook is obtained by submitting each new version to OHP.Materials@state.or.us.

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Enrollment and Disenrollment
Department: Member Services	Policy Number: MS10
Version: 2	Creation Date: 7/17/2019
Revised Date: 7/29/2019	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 7/30/2019

POLICY STATEMENT

To ensure member enrollment or disenrollment with Umpqua Health Alliance (UHA) meets the requirements of Code of Federal Regulations (CFR) 42 CFR § 438.56 and the Coordinated Care Organization (CCO) Contract Exhibit B, Part 3, Section 8 and 9.

PURPOSE

A member has the right to request disenrollment. Likewise, UHA has the ability to request the disenrollment of a member under certain circumstances. The guidelines describing when disenrollment is appropriate is outlined below, however does not guarantee disenrollment. The disenrollment of a member is at the sole discretion of Oregon Health Authority (OHA).

RESPONSIBILITY

Member Services

DEFINITIONS

Member Representative (i.e. personal representative): Anyone the member has designated as his or her representative which can include a community health worker, foster parent, adoptive parent, or other provider/person given this authorization (H11 – Personal Representatives).

PROCEDURES

Member Enrollment

1. UHA considers an individual as a member beginning on the eligibility effective date that OHA enrolls the member with UHA.

2. OHA will enroll a member with the CCO selected by the member. If an eligible member does not select a CCO, OHA may assign the member to a CCO selected by OHA in accordance with 42 USC § 1396u-2(a)(4)(D).
3. UHA will remain open to enrollment at all times and shall accept, without restriction all eligible members in the order in which they apply and are enrolled with UHA by OHA, unless enrollment has been closed. Enrollment can only be closed by:
    a. OHA upon administrative notice to UHA's Contract Administrator or upon failure to maintain an adequate provider network sufficient to ensure timely member access to services. This applies to adjustments to UHA's service area described in the CCO Contract Exhibit B, Part 4, Section 14.
    b. The request of UHA via administrative notice to OHA's designated OHA CCO Coordinator, if and when UHA's maximum enrollment has been reached, or for any other reason mutually agreed upon by OHA and UHA, or as otherwise authorized under the CCO Contract or OAR 410-141-3060.
4. Upon the date of enrollment, UHA will provide members with all covered services with the following eligibility requirements/exceptions:
    a. For persons who are enrolled on the same day as they are admitted to the hospital or, for children and adolescents admitted to psychiatric residential treatment services (PRTS), UHA is responsible to cover these services.
    b. If the person is enrolled after the first day of a hospital stay or PRTS, the person will be disenrolled, and the date of enrollment shall be the next available enrollment date following discharge from hospital services or the PRTS.
5. If OHA enrolls a member with UHA in error, OHA will apply the disenrollment rules in OAR 410-141-3080 and may retroactively disenroll the member from UHA and enroll the member with the originally intended CCO up to 60 days from the date of the erroneous enrollment. OHA will adjust the CCO payments to UHA accordingly.
6. UHA shall actively participate with Department of Health and Human Services (DHS) and OHA to transition dual eligible beneficiaries from partial CCO/fee-for-service (FFS) enrollment to CCO-A during dual passive enrollment initiative.
7. UHA shall not discriminate against individuals eligible to enroll, nor disenroll, on the basis of health status, the need for health services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability and shall not use any policy or practice that has the effect of discriminating on the basis of such foregoing characteristics or circumstances (MS2 – Nondiscrimination of Member).

	Policy Name: Member Enrollment and Disenrollment
Department: Member Services	Policy Number: MS10
Version: 2	Creation Date: 7/17/2019
Revised Date: 7/29/2019	Review Date:

Member Disenrollment

1. All disenrollment requests, whether enrollment is mandatory or voluntary must be in compliance with 42 CFR § 438.56 and OAR 410-141-380. UHA considers an individual to no longer be a member as of the effective date of the member's disenrollment from UHA. As of that date, UHA is no longer required to provide covered services to the individual, unless the member is hospitalized at the time of disenrollment. In such an event, UHA is responsible for inpatient hospital services until discharge or until the member's primary care provider (PCP) determines that care in the hospital is no longer medically appropriate. OHA will assume responsibility for other services not included in the Diagnosis Related Group (DRG) applicable to the hospitalization.
2. A member or member representative may request disenrollment orally or in writing directly to OHA (or its agent) and/or to UHA, who will then forward on the request to OHA or DHS Eligibility. A disenrollment request with cause is allowed at any time, requests without cause are allowed for the following reasons:
    a. Without cause:
        i. Oregon Health Plan (OHP) clients auto-enrolled or manual-enrolled in error may change CCOs, if another CCO is available, within 30 days of the member's enrollment;
        ii. Newly eligible members may change CCOs, if another CCO is available, within 12 months of their initial enrollment or the date OHA sends the notice of the enrollment, whichever is later;
        iii. During the 90 days following the date of the member's initial enrollment into the CCO, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later;
        iv. A member may request disenrollment during "OHP eligibility renewal," as such term is defined in OAR 410-141-3060, which is typically 12 months;
        v. Members who are eligible for both Medicare and Medicaid and members who are American Indian/Alaska Native (AI/AN) beneficiaries may change CCOs or disenroll to FFS at any time;
        vi. Upon automatic re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity;

vii. Whenever the member's eligibility is re-determined by OHA; or
viii. When the OHA imposes the intermediate sanction specified in 42 CFR § 438.702(a)(4) and the CCO Contract.

b. With cause:
   i. Members may change CCOs or disenroll to FFS at any time with cause, as defined in 42 CFR Part 438; or
   ii. Because of moral or religious objections, UHA does not cover the service the member seeks; or
   iii. The member needs related services to be performed at the same time, not all related services are available within the provider network, and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
   iv. For members that use managed long term services and supports (MLTSS), the member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the CCO and, as a result, would experience a disruption in their residence or employment.
   v. For other reasons, including but not limited to, poor quality of care, lack of access to services covered under the CCO Contract, an insufficient provider network, or lack of access to participating providers experienced in dealing with the Member's health care needs. Examples of sufficient cause include but are not limited to:
      1. The member moves out of the service area;
      2. Services are not provided in the member's preferred language;
      3. Services are not provided in a culturally appropriate manner;
      4. It would be detrimental to the member's health to continue enrollment; or
      5. For continuity of care.

3. UHA may request that OHA disenroll a member as allowed by the CCO contract if:
   a. The member is uncooperative or disruptive, except where this is a result of the member's special needs or disability; or
   b. The member commits fraudulent or illegal acts such as permitting the use of such member's OHP Client identification card by a third-party, altering a prescription, theft or other criminal acts committed in or on UHA's or a provider's premises.

4. The request by UHA to disenroll a member can be expedited if:
    a. The member makes a credible threat to cause grievous physical injury, including but not limited to, death to others in the near future, and that significant risk cannot be eliminated by a modification of policies, practices or procedures; or
    b. Commits an act of physical violence, to the point that the member's continued enrollment with UHA seriously impairs the ability to furnish services to either the member or other members.
5. If disenrollment occurs due to an illegal act which includes member or provider Medicaid Fraud, UHA will report to the OHA Office of Payment Accuracy and Recovery, consistent with 42 CFR § 455.13 by one of the following methods:
    a. Fraud hotline 1-888-FRAUD01 (1-888-372-8301); or
    b. Via on-line portal at https://apps.state.or.us/cf1/OPR_Fraud_Ref/index.cfm?act=evt.subm_web
6. UHA may not request that OHA disenroll a member solely for reasons listed below:
    a. Because of a physical, intellectual, developmental, or mental disability;
    b. Because of an adverse change in the member's health;
    c. Because of the member's utilization of services, either excessive or lack thereof;
    d. Because of the member's effect (positive, neutral, or negative) on provider's CCO quality metrics;
    e. Because the member requests a hearing;
    f. Because the member exercises his or her option to make decisions regarding their medical care with which UHA disagrees;
    g. Because of uncooperative or disruptive behavior resulting from the member's special needs, disability, or any condition that is a direct result of their disability, unless otherwise permitted under:
        i. The member being in the custody of DHS/Child Welfare;
        ii. Prior to the member receiving any services, including, without limitation anticipated placement in or referral to a Psychiatric Residential Treatment facility;
        iii. A member's decision regarding their own medical care with which UHA disagrees; or
        iv. For any other reasons that may be specified in OAR 410-141-3080.
7. The effective date of disenrollment when requested by a member will be the first of the month following OHA's approval of disenrollment. If OHA fails to make a disenrollment

determination by the first day of the second month following the month in which the member files a request for disenrollment, the disenrollment is considered approved.

8. If OHA disenrolls a member due to an OHA administrative error, and the member has not received services from another CCO, the member may be retroactively re-enrolled with UHA up to 60 days from the date of disenrollment.
9. If OHA disenrolls a member retroactively, OHA will recoup any CCO payments received by UHA after the effective date of disenrollment. If the disenrolled member was otherwise eligible for the OHP at the time of service, any services the member received during the period of the retroactive disenrollment may be eligible for FFS payment under OHA rules.

CORPORATE POLICY & PROCEDURE

	Policy Name: Data Validation Process
Department: Quality Improvement	Policy Number: QI04
Version: 2	Creation Date: 12/7/2017
Revised Date: 4/05/19	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Harvard	☐ Physician eHealth Services
☐ Umpqua Health - Newton Creek	☐ Umpqua Health Network
☐ UHA Community Activities	☐ ACE Network
☐ Professional Coding and Billing Services	☐ Umpqua Health - Transitional Care

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 04/23/2019

POLICY STATEMENT

Umpqua Health Alliance (UHA) will provide review and validation of Coordinated Care Organization (CCO) quality metrics data that is regularly and timely used in reporting to its provider network for purposes of assessing provider performance as described in OAR 410-141-3180 and OAR 410-141-3200.

PURPOSE

The purpose of this policy is to describe the processes used by UHA to ensure that CCO quality metrics data used in the evaluation of UHA provider performance is consistent with OHA "CCO Measure Specification Sheets" and with claims data analytics used in assessing performance by eligible providers.

RESPONSIBILITY

Quality Improvement (QI)

DEFINITIONS

CCO Quality Metrics: The Oregon Health Authority (OHA) uses quality health metrics to show how well CCOs are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care. Outcome and quality measures are developed and updated by the Metrics and Scoring Committee, the OHA subcommittee established in accordance with ORS 414l.638(1). Funds from a quality pool will be awarded to CCOs based on their annual performance on these CCO Incentive Measures.

CCO Measure Specifications Sheets: The specifications used to produce the measures are available from the OHA's Office of Health Analytics. Measures are produced using national and standardized specifications. Variations and criteria are noted in the documents.

Event Spec File: The specifications used to extract Electronic Clinical Quality Measure (eCQM) data from the Electronic Health Records (EHRs).

	Policy Name: Data Validation Process
Department: Quality Improvement	Policy Number: QI04
Version: 2	Creation Date: 12/7/2017
Revised Date: 4/05/19	Review Date:

PROCEDURES

CCO Quality Metrics are measured at the assigned Primary Care Provider (PCP) level in assessing performance for certain qualified UHA CCO contracted providers. Pursuant to the OHP Health Plan Service Contract, Exhibit B, Part 4, Section 10; at a minimum, data validation is processed annually. Data used in this analysis is produced using approved, Business Intelligence (BI) analytics software vendors and validated by UHA employed data analytics and Quality Improvement staff, using the methods described below.

1. Refer to the OHA "CCO Measure Specification Sheets" to determine the parameters for each metric.
2. UHA Third Party Administrator (TPA) sends a Claims Processing System (CPS) file to BI vendor on a daily basis. The CPS file includes all Medicaid data and is used by BI vendor to calculate CCO metric performance.
3. A custom query of claims based on the metric specifications in the same date range as the report is created. The query may be done for the entire CCO population or the subset pertaining to an assigned PCP.
4. Verify eligible member data totals for numerator and denominator pertaining to each CCO quality metric to obtain an accuracy significance level of at least 0.05, and then calculate the rates based upon the calculations designated in the CCO Measure Specification Sheets.
5. All new metrics and metric updates are communicated to the UHA QI team's designated point of contact from OHA via email notification.
    a. Once notified, the UHA QI team notifies its BI vendor of the update or new metric and receive a response with confirmation of receipt and an assigned case number for reference along with an estimated date of completion.
        i. Bi-weekly progress updates occur between the BI vendor and UHA QI Department to address ongoing work requests.
        ii. The BI vendor performs its own internal validation while completing the update request.
        iii. Once completed, updates are pushed to live sites by the BI vendor and communicated to users via enhancement updates.
    b. Internal UHA validation of metric requirements is ongoing and additional review is performed as needed.
    c. Basic edits, errors, and questions are communicated to BI by UHA QI via email with a responding case number and estimated time of completion.
        i. Bi-weekly progress updates between BI and UHA QI includes a review of all outstanding items.
6. For Non-Centricity EHRs UHA works with BI vendor to develop an Event-Spec file based on OHA's measure specifications, the Non-Centricity EHRs IT resources are used to extract the data per the Event-Spec file requirements; the data [flat] file is then sent to

	Policy Name: Data Validation Process
Department: Quality Improvement	Policy Number: QI04
Version: 2	Creation Date: 12/7/2017
Revised Date: 4/05/19	Review Date:

UHA using a Secure File Transfer Protocol (SFTP) site. UHA Quality Improvement and Decision Support Departments review and validate the file for onward transmission to the BI vendor. Once the file is received the BI vendor uploads the measure specific data to its online BI platform.

CORPORATE POLICY & PROCEDURE

	Policy Name: Member Engagement in Quality Programs
Department: Quality Improvement	Policy Number: QI07
Version: 1	Creation Date: 10/25/2019
Revised Date:	Review Date:

Line of Business: ☐ All

☒ Umpqua Health Alliance	☐ Umpqua Health Management
☐ Umpqua Health - Newton Creek	☐ Physician eHealth Services
☐ UHA Community Activities	☐ Umpqua Health Network
☐ Professional Coding and Billing Services	☐ ACE Network

Signature:

Approved By: Michael A. von Arx, Chief Operating Officer Date: 10/28/2019

POLICY STATEMENT

Umpqua Health Alliance (UHA) is committed to having a robust Quality Improvement (QI) Program in which it effectively engages its members, while also receiving feedback from the membership on how the QI Program affect them and could be improved.

PURPOSE

The purpose of this policy is to outline the steps that the QI Department will take to solicit feedback from members and the public about the impact of its QI Program, as well as outline the type of engagement activities the department may conduct.

RESPONSIBILITY

Quality Improvement

DEFINITIONS

None

PROCEDURES

1. In an effort to communicate and receive feedback from its members on the impact of its QI Program, UHA will engage in the following activities:
    a. Community Advisory Council (CAC) Reporting.
        i. UHA will provide a quarterly report to its CAC, which includes members, on the following domains:
            1. Metric reporting and the impact to members.
            2. Appeals and grievance trends.
            3. Member engagement campaigns and activities.
            4. Status and progress of its Transformation & Quality Strategy (TQS) Program.
        ii. During the presentation, the CAC will ensure members and the public have the opportunity to provide written or oral comments on UHA's QI Program.

1. UHA will utilize that feedback to make any future adjustments to its programs.

b. Board of Director Reporting.
   i. At least annually, the QI Department will provide a report to UHA's Board of Directors on its QI Program and its impact on members.
      1. The UHA Board of Directors meeting is open to the public in which members and the public are encouraged to provide oral or written comments on UHA's QI Program.
         a. The QI Department will utilize any feedback for future enhancements to its program.

c. Member Surveys.
   i. UHA may also consider soliciting feedback on its QI Program by engaging in targeted member surveys.
      1. In the event UHA does engage in a survey during any year, the summary of the results will be communicated to UHA's Quality Improvement Committee (QIC) as well as the CAC.
   ii. The QI Department will also review results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey administered by the Oregon Health Authority, to engage insight on improvement areas and member experience.

2. As part of its Member Engagement Strategy, UHA will identify how it will engage its membership on QI initiatives. Such initiatives may include:
   a. Underutilization Outreach.
      i. UHA's QIC and Utilization Management Committees look to detect any areas of underutilization.
      ii. If scenarios present themselves in which underutilization is present, UHA's QI Department will be tasked with developing the necessary tactics to effectively engage members to increase utilization. Related tactics may include:
         1. Mail or telephonic outreach to members.
         2. Reminders to members and their PCPs when members have not received preventative services as outlined in Exhibit B, Part 2, Section 6(a)(2) of the Coordinated Care Organization (CCO) Contract.
         3. Referral to Case Management for assistance.
      iii. Some examples of the types of underutilization that are evaluated for includes:
         1. Members not receiving preventatives services, such as those recommended by the U.S Preventative Service Task Force.

2. Special populations who have not received related care (e.g. members designated with severe and persistent mental illness (SPMI)).
    a. Example: Members with SPMI that have not received a behavioral health service in a year.

b. CCO Metric Gaps.
    i. Annually, the QI Department will review the CCO Metrics and determine what specific member engagement activities it could engage in to reduce healthcare gaps.
    ii. The tactics identified will be rolled into UHA's Member Engagement Program. The department will report the outcome of its tactics to the QIC.
    iii. Such tactics may include:
        1. Direct member outreach on care gaps.
        2. Member incentives.
        3. Community initiatives, such as campaigns with public health, schools, etc.

c. Provider Led Initiatives.
    i. To encourage member engagement, the QI Department may also develop tactics in which it leverages the provider-member relationship to improve quality.
    ii. Such activities in which UHA would utilize its contracted providers to enhance member engagement could include:
        1. Office workflow analysis to improve patient experience and satisfaction.
        2. Technical assistance on quality initiatives to reduce any barriers that may impact members.
        3. Specialize trainings (e.g. motivational interviewing) to assist providers in engaging members on quality initiatives more effectively.

Department	Standard Operating Procedure Title	SOP Number	Effective Date	Version Number
N/A	N/A	N/A	N/A	N/A

AGENDA

Member Engagement & Health Equity Committee
Zoom Meeting/Audio
April 17, 2020 – 2pm-4pm

	TIME	ITEM	OWNER
1.	10 mins	Introductions	All
2.	5 mins	Committee Charter	Dr. Tanveer Bokhari
3.	20 mins	External Member Updates	Melanie Prummer, Analicia Nicholson, Dennis Eberhardt, Rev. Howard Johnson
4.	15 mins	SDOH, HE and Community Engagement Strategy Plan	Tanveer
5.	10 mins	UH Health Equity Plan (draft) Overview/OHA Guidance Document and FAQ	Tanveer
6.	10 mins	Clinical Advisory Panel (CAP)/Quality Advisory Committee (QAC) /Credentialing Committee Overviews	Dr. Douglas Carr
7.	10 mins	Pharmacy & Therapeutics (P&T) Committee Overview	Robin Trevor
8.	10 mins	Member Newsletter Workgroup Overview	Naomi Brazille
		Adjourn	

Materials Sent Out (.pdf page)

2. ME HE Committee Charter
4. Strategy Document
5. Draft/OHA Guidance Doc & FAQ
6. Charters and Minutes for CAP/QAC
8. Two Member Newsletters - from UHA website

Next Meeting: Date | Time | Location: list here

MINUTES

Member Engagement & Health Equity Committee

Zoom Meeting/Audio

April 17, 2020 – 2pm-4pm

	Speaker	Topic
1.	Team	**Introductions** • Dr. Tanveer Bokhari, VP Quality & Health Equity • Heidi Larson, Executive Assistant • Dr. Douglas Carr, Chief Medical Officer • Naomi Brazille, Claims Administration • Robin Traver, Director Clinical Pharmacy Services • Rev. Howard Johnson o has lived and served in Roseburg for nearly 30 years o Founder and Pastor of Bethany Bible Fellowship o Previous work with NAACP and currently volunteer member of Roseburg School Board • Analicia Nicholson o Assistant Superintendent of Douglas ESD o Previous work as a teacher, in public health and education • Melanie Prummer o Executive Director of Peace at Home Advocacy Center (formerly Battered Person's Advocacy) o Background of education and training in Mental Health o Non-profit management for 20 years • Dennis Eberhardt - absent o Clinic Director of Cow Creek Health and Wellness Center • Guest- Sybil White, Member Services
2.		**Committee Charter** • Dr. Bokhari reviewed the Committee Charter as attached in the packet
3.		**External Member Updates** • Dr. Bokhari, apprised the members of the work been done by the UHA SDOH Task-force, asked our external members to share updates from their communities/organizations per COVID-19 effects, specifically pointing out community needs that can be filled by UHA • Analicia Nicholson o The ESD is doing well and properly funded o The Community Uplift Program could use help during this time; the contact is Vanessa Pingleton o Online learning and connectivity is an area that may need possible community support as schools move to virtual learning platforms • Team update- it was noted that the school bus drivers are currently delivering lunches at bus stops along the day to help with food insecurity. They have added breakfast as well, leaving the evening meal to be the one in question for families.

MINUTES

Member Engagement & Health Equity Committee
Zoom Meeting/Audio
April 17, 2020 – 2pm-4pm

		• Melanie Prummer
		  o Was able to meet with Governor Brown, who expressed and offered support in the important work of getting the word out- that Peace at Home Advocacy is still open and serving during the COVID-19 restrictions and lockdowns
		  o Other agencies, including UHA, are also helping to spread the word via social media, newsletters, etc.
		  o In daily contact with the food banks- they are short both of funds and of volunteers
		• Rev. Howard Johnson
		  o Noted the stress to the community based on deep job losses and company closures
		  o Additionally, raw product transportation systems are at risk and this causes additional stresses and shutdowns
		  o Homelessness was addressed and Rev. Johnson asked for the committee's clarification on the definition of homelessness; Dr. Bokhari agreed that schools and other organization often define it differently. Analicia took an action item to come back to the committee with the schools' definition. Dr. Bokhari took an action item to bring to the committee UHA's definition.

4.		**SDOH, HE and Community Engagement Strategy Plan** • Dr. Bokhari reviewed the six key objectives and strategies that comprise UHA's greater SDOH strategy and the community engagement piece of the Health Equity Plan (draft). • Dr. Bokhari explained that a vital part of this committee's mission is to provide feedback and ideas to UHA as to these specific documents, strategies, and plans
5.		**UH Health Equity Plan (draft) Overview/OHA Guidance Document and FAQ** • Dr. Bokhari reviewed the UHA Health Equity Plan draft as well as the OHA Guidance Document and FAQ Document • Dr. Bokhari explained that a vital part of this committee's mission is to provide feedback and ideas to UHA as to these specific documents, strategies, and plans • Analicia Nicholson shared the feedback that UHA should compare its data to schools; ESD data shows that 1 in 5 K12 students is a person of color- this data does not match the ESD's. Dr. Bokhari will follow up to compare UHA data to available student diversity data. Currently UHA has member demographic data such as languages spoken, TANF recipients, etc., which helps inform the Health Equity Plan.

MINUTES

Member Engagement & Health Equity Committee
Zoom Meeting/Audio
April 17, 2020 – 2pm-4pm

6.		**Clinical Advisory Panel (CAP)/Quality Advisory Committee (QAC) /Credentialing Committee Overviews** • Dr. Carr reviewed the purpose and background of the following: o Clinical Advisory Panel (CAP) – shared charter and minutes from last meeting on 3/18/20 o Quality Advisory Committee (QAC) – shared charter and minutes from last meeting on 2/26/20 o Credentialing Committee – shared charter
7.		**Pharmacy & Therapeutics (P&T) Committee Overview** • Robin Traver reviewed the purpose and background of the Pharmacy and Therapeutics (P&T) Committee • Charter was shared with the committee
8.		**Member Newsletter Workgroup Overview** • Naomi Brazille shared the Winter 2020 edition of the Member Newsletter and walked through its component elements. • This newsletter is published quarterly and whenever a special update is called for, such as with COVID-19. • Additionally the Member Newsletter is available in Spanish, Thai, Russian, and Chinese languages
		Wrap-Up/Adjourn • Dr. Bokhari encouraged, ongoing, regular feedback from this committee to inform the greater UHA Health Equity committee • Dr. Bokhari also encouraged all members to regularly update this committee as to community SDOH issues and needs • Lastly, this committee is encouraged to give its feedback on all elements of UHA's Health Equity Plan as it is drafted and presented

Action items on next page -

MINUTES

Member Engagement & Health Equity Committee
Zoom Meeting/Audio
April 17, 2020 – 2pm-4pm

Action Items

1. Analicia Nicholson and Dr. Bokhari will bring back to the committee schools and UHA definition of homelessness

2. Analicia Nicholson will share with Dr. Bokhari ESD demographic information in order to better inform UHA's understanding of diversity and SDOH needs within its community and member populations

3. Melanie Prummer will send to Naomi Brazille information on Peace at Home's availability and services to be included in a future UHA Member Newsletter

4. Naomi Brazille will send to the committee a link to the current Member Newsletter page online

5. Heidi Larson will send out to the committee a roster with committee member contact information; additionally, calendar information will be solicited for the next committee meeting

6. All committee members will bring back their agency/community feedback for SDOH needs to the next meeting

Next Meeting: Date/Time will be elicited via email

AGENDA

Health Equity Committee
Zoom Meeting

April 22, 2020 – 2pm-4pm

	TIME	ITEM	OWNER
1.	10 mins	Introductions	All
2.	5 mins	Committee Charter	Dr. Tanveer Bokhari
3.	15 mins	Present: Minutes of Member Engagement & Health Equity (ME HE) Committee	Tanveer
4.	15 mins	SDOH, HE and Community Engagement Strategy Plan	Tanveer
5.	15 mins	UH Health Equity Plan [draft] Overview/OHA Guidance Document and FAQ	Tanveer
6.	10 mins	SDOH Dashboard Document	Tanveer
		Adjourn	

MINUTES

Health Equity Committee
Zoom Meeting
April 22, 2020 – 2pm-4pm

	ITEM
1.	**Introductions** • Dr. Tanveer Bokhari, VP Quality & Health Equity o Dr. Bokhari noted that he and Sharon Stanphill are co-chairs of this committee, and that only the two UHA board members on the committee- Sharon Stanphill and Jerry O'Sullivan- have the power to vote. Dr. Bokhari, joined UHA in Aug-2018, and is presently working with dual roles of VP Quality and as the CCO's Health Equity Administrator (HEA); the HEA will be responsible and accountable for all matters relating to Health Equity within the CCO, CCO Provider Network, and CCO service area. • Sharon Stanphill, CHO, Cow Creek Band of Umpqua Tribe of Indians o Sharon is co-chair of the Health Equity committee and serves on the UHA board. Sharon has served the Cow Creek Band for 22 years; she is excited about sharing with this committee information about tribal needs, mission, and culture as well as sharing best practices. • Jerry O'Sullivan, Senior Director of Operations for ADAPT o Jerry has 11 years of experience in his current role with a background in addiction and mental health. He also serves as the chair for the Community Advisory Council at UHA, helping to channel funds and shape policies to help the community. • Nancy Rickenbach, VP Clinical Engagement, o Nancy joined UHA the first week of April; she has 30 years' worth of experience in Medicaid and other managed care. • Dr. Douglas Carr, CMO o Dr. Carr has been with UHA approximately 2. 5 years; he is currently serving in a dyad leadership model with Nancy. • Elaine Schweitzer, CFO o Elaine has worked for Umpqua Health for just a little over a year; she has 30 years of experience in the fields of finance, healthcare, and Medicaid. • Mike Von Arx, COO o Mike has been with Umpqua Health for 4 years; he has experience working for large national organizations, with a background in compliance and mental health. • Lindsey Baker, Executive Administrator o Lindsey explained she is serving on this committee as a liaison for Brent Eichman, CEO. • Heidi Hill, VP Transformation

MINUTES

Health Equity Committee
Zoom Meeting
April 22, 2020 – 2pm-4pm

	o Heidi has been with Umpqua Health as of Feb. 17th; her role is to oversee strategic objectives, board directives, and to contribute to the Health Equity member engagement experience as well.
2.	**Committee Charter** • The finalized charter was shared with the committee in the packet • This committee will report to the Umpqua Health Alliance Board of Directors and will provide quarterly reports • This committee will meet twice a quarter for an hour minimum • A question arose as to how voting will work; Dr. Bokhari and Sharon will take the topic offline to further define the process for this committee • Dr. Bokhari shared the OHA definition of Health Equity with the committee as it is referenced in the charter o Jerry reflected that our community also faces disadvantages due to geography and socio-economics. He noted that the OHA definition of Health Equity is phrased very positively, focusing on goals. o Sharon added that after CCO 2.0 the tribes really got a voice, and expressed that they felt grateful and inspired to help bring about this picture of health equity. There is appreciation to see the priority the state is putting on health equity for all populations, including the tribes.
3.	**Present: Minutes of Member Engagement & Health Equity (ME HE) Committee** • This committee will oversee the Member Engagement and Health Equity Operational Committee • Dr. Bokhari shared the demographic makeup of the ME HE committee. • Heidi Larson will send a copy of the ME HE committee charter out to this committee • Minutes from the ME HE committee and its supporting committees were shared with this committee; Dr. Bokhari presented the summary of the ME HE committee minutes
4.	**SDOH, HE and Community Engagement Strategy Plan** • Dr. Bokhari, presented UHA's SDOH, HE and Community Engagement Strategy. He outlined the six key objects: SDOH-E/REAL+D Data Collection and Use; Workforce Diversity and Inclusion Plan; Health Equity Pan & Process; Community Engagement Plan; SDOH Engagement Process and Traditional Health Worker Expansion.

	• Dr Carr pointed out that there are lots of funding mechanisms that are now in play. CAC often looks at funding issues around HRS, funding that is in two broad categories: community benefit initiatives, and- throughout the year- the health plan itself through case managers will fund immediate needs (referred to as "flex services") that are not specifically "medical" in nature, but are health related services- this is a medical cost of the health plan. After medical costs are paid, and the administrative cost of the plan, if there are funds left over, then they can be utilized in a more liberal way for SDOH projects- a possibility for additional funding. <u>(Action Items)</u> 1. Mike- OHA released info between HRS vs. SDOH, bring back to the committee next time, HL AI 2. Elaine- as we understand more of the funding structure, maybe she can report back to next comm mtg • (background) Elaine- OHA requirement to come up with formal funding plan to present to the board for approval that ensures right comm partners are involved and SDOH is administered o Timing 3rd quarter – should come to this comm for approval • Sharon- THW – is this the only place it will be addressed? Yes, being developed with PN, member services, clinical engagement, once the plan is developed it will be brought to this committee. (reporting to OHA is separate) Elaine agrees that this committee is where this should all be looked at- whole process (ex- diabetes life style coach as TWH) • Mike- deliverables – look at payment methodologies. Some are ill-defined, some are new. States date expectation? Start by identifying where they are in the community- we don't have the line of sight • Dr carr- BH strategy also contains THW
5.	**UH Health Equity Plan [draft] Overview/OHA Guidance Document and FAQ** • Dr. Bokhari reviewed the OHA Guidance documents and explained their relationship to the Health Equity Plan, as well as the timelines. He described the role of the HEA as outlined in the OHA Guidance document and the CCO 2.0 contract.

	• The second Health Equity Plan draft (being worked now), will first be presented to the ME HE Committee for feedback before coming to this Committee for comment. • Dr. Bokhari updated the committee on the changed OHA deadlines for CCO Health Equity Plans. The deadline itself has been removed and instead replaced by a window to provide technical assistance to the CCO's; this window falls between June 30th and Dec. 31st of 2020. With the extra work from COVID-19, OHA wanted to save the CCO's from being overburdened. • The planned process for this committee is to review the existing Health Equity draft plan; then the formal Health Equity Plan itself. It is the job of the committee to provide feedback on this Plan (to be presented in June) and to share that feedback with the greater UHA board (to be presented in June as well). Once the board has given its feedback, the Health Equity Plan will be shared with OHA during its technical assistance window; once OHA makes its recommendations, the plan will come back to this committee for change and review. • Dr. Bokhari noted that as part of the Health Equity Plan OHA will need to hold a public meeting; hopefully with the date extensions from OHA we will be able to have one when COVID-19 restrictions ease.
6.	**SDOH-E Provider Training Update** • Dr. Bokhari shared with the committee the meeting summary and survey results from this training session • PCP feedback was informative, indicating large effects on patient populations from socioeconomic inequities • Health data is also being collected on patient populations with chronic disease, and disparity is being analyzed in this data set. • As an outcome of this training and feedback, work is being done to analyze, and then focus and engage with those sub-populations designated as having these issues due to race/co-morbidities, etc.

Next Meeting: Date | Time | Location: list here

AGENDA

Health Equity Committee
Virtual – Zoom Meeting
May 27, 2020 – 2pm-4pm

Please mute you line when not speaking.
Meeting will be RECORDED for minute-taking.

	TIME	ITEM	OWNER
1.	10 min	Follow up Items	Sharon/Tanveer
2.	5 min	OHA Interpreter Report Request	Tanveer
3.	10 min	SDOH Spending Readiness Self-Assessment (SRSA) Template – SHARE Initiative	Tanveer
4.	40 min	Guest Speaker – KC Bolton, MA, MHA, FACHE; CEO, AVIVA Health Community Action Process	KC Bolton
5.	10 min	Health Equity Plan Draft Update	Tanveer
6.		Adjourn	

Next Meeting: July 29, 2020 | 2-4pm | Location: Zoom Meeting

MINUTES

Health Equity Committee
Virtual – Zoom Meeting
May 27, 2020 – 2pm-4pm

	ITEM	OWNER
1.	**Commencement** • The meeting commenced at 2:10pm	
2.	**OHA Interpreter Report Request** • Dr. Bokhari shared OHA's recent request for UHA's current status on Language Access and UHA's comprehensive and robust response.	**Tanveer**
3.	**SDOH Spending Readiness Self-Assessment (SRSA) Template – SHARE Initiative** • Required under the contract and OAR's to complete this template • OHA has delayed the due date due to COVID-19 from June 2020 to December 2020 • Idea is for CCO's to move their investments from traditional areas to SDOH spending • Having a common CHIP or Community Health Improvement Plan is another way that will help us to address the four SDOH-HE domains delineated by OHA: o Neighborhood and Built Environment o Economic Stability o Education o Social and Community Health • Opportunity to work with other organizations that are already addressing this SDOH work in the community	**Tanveer**
4.	**Guest Speaker –** **KC Bolton, MA, MHA, FACHE; CEO, AVIVA Health** **Community Action Process** • Recently filled the role of Incident Commander for the County • Expectation management was a part of it- no intention of crisis response being also a way to fix systemic issues of the county. Wanted to address acute needs due to COVID-19 impacts. • Systemic, chronic, long-term issues of the county were tabled, and are the inspiration for this conversation.	**KC Bolton**

	• There exists an opportunity in this community to bring multiple agencies together to tackle the complex SDOH-E challenges that exist in Douglas County. • Homelessness is one of these- one of the top topics as a challenge the county faces. • How to go forward- can we get the right players at the table? • Are the players empowered? • How do you prioritize? • What is the role of civic organizations, government, and non-government organizations (NGO's) • The Ford Family Foundation does not see this as their role; they enable projects, not provide long-term guidance and leadership • Looking for: is there a way to start an immediate response that leads into addressing the chronic issues of the county? • Seems to be a divide between DHS and OHA • Seems to be a disconnect between the county and the city • Even well-meaning agencies are sometimes not aligned when they envision different solutions for the same problem • Lastly, how does the CAC fit in? Does it drive this work, a funnel, a conduit? • Jerry made the following points: o We need to find a solution with the following criteria: 1) something we can trust that is effective, 2) has some kind of funding or regulatory piece that makes it possible to be successful, 3) allows local organizations to buy into it rather than being something that replaces all the work they are doing. o It's not going to be up to the city and county to solve these SDOH issues, but we have to have something they can participate in, or allow to happen, that's going to be their role. It's going to be mostly up to non-profits and to individuals who are willing to participate in this work. • Noted the absence of ADAPT in the Network of Care • Interest in forming a shared CHIP via Network of Care	
5.	**Health Equity Plan Draft Update**	**Tanveer**

MINUTES

Health Equity Committee
Virtual – Zoom Meeting
May 27, 2020 – 2pm-4pm

	• Sections 1 and 2 are nearly complete; other sections must be complete • As soon as the Plan is complete, it will be brought to this committee for review and feedback	
6.	**Adjourn** • The meeting adjourned at 3:40pm	

Next Meeting: July 29, 2020 | 2-4pm | Location: Zoom Meeting

UMPQUA HEALTH

Umpqua Health Alliance Workforce Diversity and Inclusion Plan

February, 2020

TABLE OF CONTENTS:

2020 Workforce Diversity and Inclusion Plan

VISION OF THE PLAN:

UHA is committed to addressing health equity (HE) and the social determinants of health, including the cultural, socioeconomic, racial and regional disparities in the workforce as part of our organizational affirmative action plan.

As part of a workforce diversity and inclusion plan, UHA will recruit, retain and promote at all levels, diverse personnel and leadership that are representative of the demographic characteristics of Douglas County, including bridging inequalities in employment and pay, increasing access to education, promotion diversity.

DIVERSITY:

Diversity is defined by who we are as individuals. UHA recognizes that its strength comes from the dedication, experience, talents, and perspectives of every employee. Diversity encompasses the range of similarities and differences each individual brings to the workplace, including but not limited to national origin, language, race, color, disability, ethnicity, gender, age, religion, sexual orientation, gender identity, socioeconomic status, veteran status, and family structures.

INCLUSION:

Inclusion is the process of creating and maintaining a work culture and environment that recognizes, appreciates, and effectively utilizes the talents, skills, and perspectives of every employee in the achievement of UHA's objectives and mission; connects each employee to the organization; and encourages collaboration, flexibility, and fairness.

IMPLEMENTATION:

The strategies contained in this plan will be implemented in 2020-2024. UHA's Human Resources department will oversee the implementation of the plan to promote leadership engagement on diversity and inclusion issues. UHA's HR Department will work with the Health Equity officer to develop a process for gathering stakeholder input on the plan-draft, and will submit the final draft for approval to the UHA HE Committee for approval. UHA's HR department will submit progress reports to the UHA HE committee once implementation begins. The reporting and delivery of actionable analytics will increase organizational awareness and engagement about diversity and inclusion throughout the Organization on an ongoing basis.

GOAL 1: WORKFORCE DIVERSITY: UHA will recruit from a diverse, qualified group of potential applicants to secure and maintain a high-performing workforce drawn from all segments of society.

STRATEGY 1: Ensure UHA's recruitment process reaches and appeals to a diverse and highly qualified pool of candidates.

ACTIONS:

a. Formalize procedures for recruitment, including days posted, sources posted, social media protocol, use of ADP, questions, designated SME's.
b. Establish, broaden and strengthen relationships with organizations that support diverse populations and provide recruitment opportunities.
    1. Colleges and Universities
    2. Veterans Organizations
    3. Organizations that support employment for individuals with disabilities.
    4. Local, state and national professional organizations, committee's or programs comprised of backgrounds for UHA occupations.
    5. Other appropriate institutions and organizations that support the employment of diverse and gender identified populations.

c. Continue to develop UHA recruiters who are skilled at reaching qualified applicants across all dimensions of diversity; recognizing and avoiding cultural bias during outreach and recruitment activities.

d. Increase the use of social media in outreach and recruitment activities to target demographically diverse audiences.

e. Expand access to workforce and recruitment analytics to:
    1. Measure the success of recruitment and outreach activities in reaching underrepresented groups.
    2. Use of ADP recruitment tools and function to full-capacity including loading interview questions and notes on all applicants.
    3. Continually looking at internal candidates with skill-set's and backgrounds for promotion and new positions.
    4. Assess progress and provide advice on recruitment, hiring and promotion trends.

EVALUATION OF STRATEGY 1:

A) Number of outreach efforts to hire diversified workforce will increase by 10% over two years.
B) Annually evaluate new policies in recruitment processes through ADP reporting.

C) Look at potential disparities and abilities of applicant pool, making application process available in a hard copy and providing applicants with community resources who may need assistance with resumes and application processes and evaluating that need annually.
D) Coach hiring-managers on cultural bias during the hiring process.

STRATEGY 2: Employ flexibilities and best practices that promote fair and consistent treatment and equal opportunity.

ACTIONS:

a. Ensure that all position openings are available and posted diversely throughout the community to ensure internal candidates as well as the public have access to apply, encouraging open and fair competition.
b. Use structured interview questions and, to the extent possible, diverse interview panel members.
c. Use of Subject Matter Experts (SME'), as needed to review job applications and, to the extent possible ensure the use of diverse SME's.
d. Train interviewers outside of the HR department on the impact of unconscious bias in the hiring process.

EVALUATION OF STRATEGY 2:

A) Implement unconscious bias training.
B) Deploy structured interview process with SME's by Q2 of 2020.
C) Implement structured questions on frequently filled positions by Q2 of 2020.

GOAL 2: WORKPLACE INCLUSION: UHA will cultivate a culture that encourages collaboration, flexibility, and fairness to enable individuals to contribute to their full potential and to improve retention.

STRATEGY 1: Continue to develop succession management and career path opportunities to retain UHA's valued and diverse workforce.

ACTIONS:

a. Continue to explore the feasibility of establishing additional opportunities for career advancement across the organization through collaboration on position management between Department management, Human Resources and Executive leadership (e.g., bridge positions, upward mobility, cross training, details and supervisory and managerial development.)
b. Analyze the results of exit interviews, 30-day surveys, and quarterly check-in's to express dissatisfaction in the workplace or choose to find employment elsewhere. Use the data to enhance working conditions to promote retention and an inclusive environment.
c. Continue using analytics from ADP and other metrics to analyze attrition to determine if dipartites exist and address any issues related to retention or succession management efforts.

d. Continue to evaluate UHA's career development and succession planning efforts and develop strategies to ensure that they contribute to a diverse pipeline of candidates especially for leadership and at the executive management levels:
    i. Management succession planning review
    ii. Pilot efforts to identify potential area of focus for future succession planning.

EVALUATION OF STRATEGY 1:

A) Create a reporting of the number of internal applicants and hires are made annually.
B) Enhance or make recommendations to Executive Staff based on results of 30-day surveys and quarterly check-in's.
C) Create a reporting mechanism for exit interviews to identify reasons for attrition and make adaptations to working conditions where possible /necessary.

STRATEGY 2: Apply career management policies and practices consistently to ensure every eligible employee has an equal opportunity for career advancement.

ACTIONS:

a. Support transparency of developmental opportunities by posting all positions on ADP and sending out monthly announcements to internal staff, ensuring the postings are accessible to all eligible employees, and systematically tracking applications and selections
b. Update ADP recruitment processes in the module to track internal candidates.
c. Continue to collaborate with executive management, Human Resources and Department managers to identify and address barriers affecting the inclusion of diverse employees in career development programs and opportunities.
d. Track employees who are taking advantage of the Corporate University opportunities and internal training to ensure diverse participation.
e. Continue to integrate coaching into Corporate University, career management and mentorship programs, specifically related to promoting diversity and inclusion.
f. Encourage participation in formal coaching, as well as informal coaching between supervisors and employees.

EVALUATION OF STRATEGY 2:

A) Implement an evaluation system to track staff who are taking advantage of the Corporate University.
B) Develop a formal coaching/mentorship program by Q4.
C) Presentation of 90% of open positions to internal staff.

STRATEGY 3: Implement an ongoing communication strategy to reinforce the commitment of all employees to diversity and inclusion.

ACTIONS:

a. Identify potential topics and ensure that internal publications such as The Insider, include articles to further promote the importance and success of diversity and inclusion to UHA.
b. Raise public awareness about UHA's diversity and inclusion efforts by sharing relevant information on the UHA external web-site, at UHA outreach events and in external reports and publications.
c. Update the UHA Equal Employment opportunity and Non-Discrimination policy in the handbook and on the ADP application website along with appropriate information about employee rights and responsibilities under civil rights and related laws, regulations and UHA policy.

EVALUATION OF STRATEGY 3:

A) 100% of the employee communication through the insider include a topic on diversity and / or inclusion.
B) Update job description template and handbook to ensure current information on Diversity and Inclusion and employment related policy is updated.

STRATEGY 4: Nurture Acceptance of Diversity and inclusion as a consistent part of UHA's work environment through continuous learning efforts.

ACTIONS:

a. Promote awareness and discussion of diversity and inclusion by focusing on issues that impact today's workplace including but not limited to, generational, gender, gender identity and veteran's issues, unconscious bias and misconceptions about working with individuals with disabilities.
b. Offer training to managers, supervisors and employees about prevention of unlawful discrimination, retaliation and harassment through in-person training, at annual manager meetings, webinars or computer based training.

EVALUTATION OF STRATEGY 4:

A) 100% employee participation and completion of cultural diversity training.
B) Additional training offered to employees and management staff throughout the year.

STRATEGY 5: Support employee inclusion by recognizing the diverse priorities and needs of employees in maintaining healthy career/work-life integration.

ACTIONS:

a. Continue to seek out and adopt policies, programs and benefits that support and enhance the career and work-life integration of employees, including telework, wellness programs and other work-life flexibilities and benefits.
b. Encourage employees and supervisors, where appropriate to enable flexible workplace policies that support employee engagement and empowerment.

c. Educate employees on the benefits of the career and work-life programs on employee retention and increased productivity.

EVALUTATION OF STRATEGY 5:

1) Increase employee participation in wellness program by 5%.
2) Evaluate and update employee telework policy as needed.

GOAL 3: SUSTAINABILITY: UHA will equip leaders with the ability to manage diversity, measure results, refine approaches on the basis of results, and institutionalize a culture of inclusion.

STRATEGY 1: Tie diversity and inclusion to UHA business success.

ACTIONS:

a. Establish UHA annual performance goals that further promote diversity and inclusion throughout UHA.
b. Promote accountability at all levels for cultivating a culture that encourages collaboration, flexibility and fairness to enable individuals to contribute to their full potential.
c. Engage Senior leadership through collaboration, consultation and communication on diversity and inclusion issues impacting UHA.
d. Report progress on the effectiveness of diversity and inclusion policies and programs at least annually to the UHA executive leadership team
e. Review the Diversity and Inclusion Plan annually and update if needed to align with UHA diversity and inclusion priorities, performance goals and other related human resource strategies to support diversity and inclusion.

EVALUATION OF STRATEGY 1:

1) Tie performance measures to diversity goals for 100% of staff in 2020.
2) Review and modify diversity plan as needed based on the outcomes of each strategy.

Recognizing & Overcoming Unconscious Bias

Audience: All employees who work in a healthcare setting

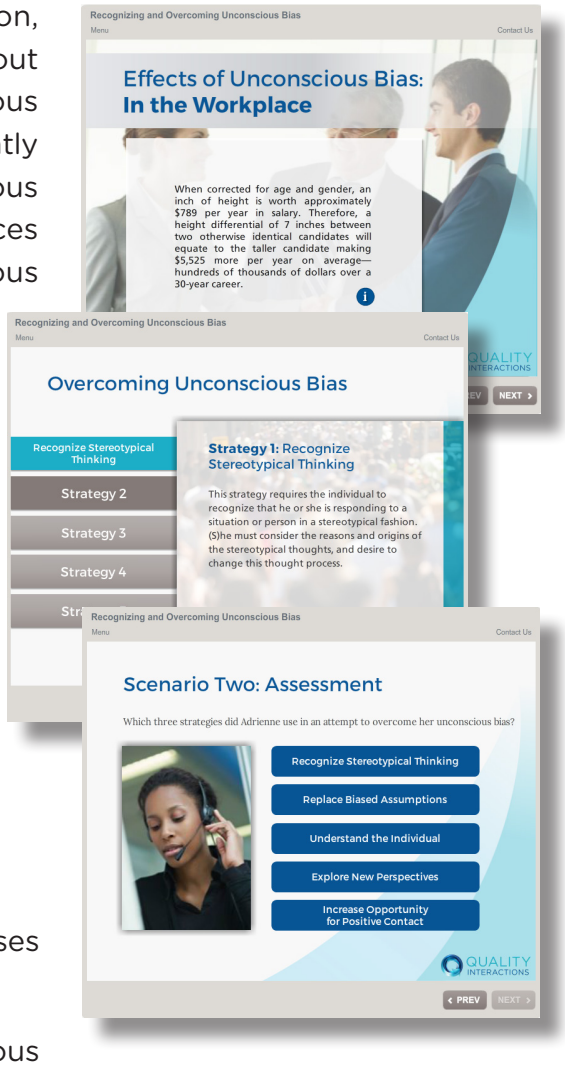
Accreditation Available: 1 CME, CEU, or CCM Credit

CE Information: qualityinteractions.com/accreditation

About This Course

In order to efficiently process vast amounts of information, the human brain makes countless decisions every day without our conscious awareness or control. While these unconscious processes are natural and necessary, they can also be significantly biased by cultural stereotypes. Research shows that unconscious biases significantly contribute to disparities in health care services and within the workplace, but that with education and conscious effort, these harmful biases can be overcome.

This course provides an essential overview of the research surrounding unconscious bias, its societal prevalence, and effects in health care and the workplace. Participants learn strategies for recognizing and addressing implicit bias, and practice applying these techniques to interactive case scenarios.



Learning Outcomes

- Understand cognitive shortcuts used by the brain to process information
- Explain unconscious bias and provide examples
- Assess the potential consequences of unconscious biases when interacting with others
- Apply strategies to minimize the impacts of unconscious bias in various settings and situations

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QUALITY INTERACTIONS
The key to high-value healthcare

ResCUE Model™ for Cross-Cultural Communication

Audience: All employees who work in a healthcare setting

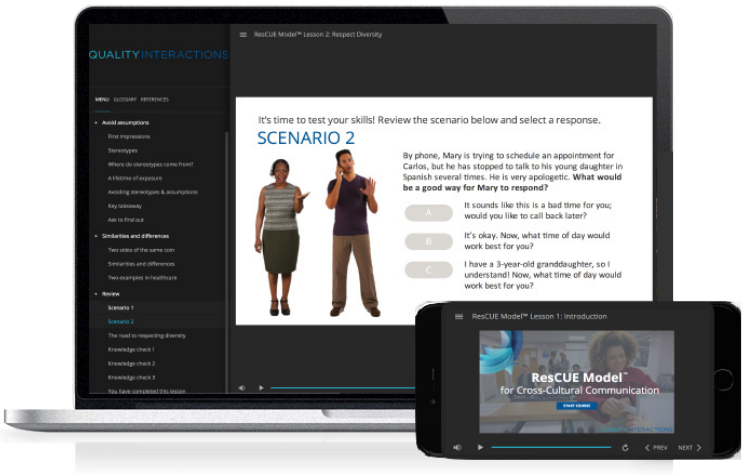
Duration: 45 minutes

About This Course

What is cultural competency, and why does it matter in healthcare? This course helps learners make the connection between culture, everyday professional interactions, and health outcomes.

Participants learn to use the action-based ResCUE Model™ to improve cross-cultural interactions in the workplace. Lessons focus on how to show respect for diversity, communicate clearly, understand and resolve differences by engaging the individual.

Chaptered learning includes interactive exercises, real case scenarios, and knowledge checks to recap key takeaways. Full audio narration is available.



Learning Outcomes

- Demonstrate respect for cultural diversity
- Communicate clearly in cross-cultural interactions
- Understand how cultural differences can impact healthcare
- Find solutions when cultural differences create conflict

"Excellent course! Made me think about everyday assumptions we make about patients without being aware." - Participant

"This course is very current, and will be for a long time. Realistic scenarios with tips were practical and informative." - Participant

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The key to high-value healthcare