2023 Transformation and Quality Strategy (TQS):

Special Health Care Needs

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Housekeeping

- Please keep yourself on mute when you're not speaking.
- Type questions into the chat at any time.
- This webinar is being recorded. The slides and recording will be available on the Transformation Center TQS TA webpage.

Agenda

- TQS background
- SHCN component overview and definitions
- SHCN requirements and opportunities for improvement
- Facilitated Q&A

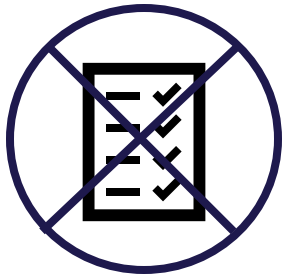
TQS background

TQS foundational principles

The TQS addresses three key principles:

1. Meet relevant CFR, OAR, 1115 waiver and CCO contractual requirements
2. Pushes health transformation through alignment with quality and innovation
3. Decrease administrative burden

Why do the work



Efficiency
is doing things right;

Effectiveness
is doing the *right* things.

– Peter Drucker

2023 TQS components

Project needs to meet the requirements for each component assigned to it.

1	Behavioral Health Integration	**8**	PCPCH: Tier Advancement
2	CLAS Standards	**9**	Serious and Persistent Mental Illness (SPMI)
3	Grievance and Appeal System	**10**	Social Determinants of Health & Equity (SDOH-E)
4	Health Equity: Data	**11**	Special Health Care Needs (SHCN): Full Benefit Dual Eligible Population
5	Health Equity: Cultural Responsiveness	**12**	SHCN: Non-duals Medicaid Population
6	Oral Health Integration	**13**	Utilization Review
7	Patient-Centered Primary Care Home (PCPCH): Member Enrollment		

Access components removed from prior year.

2023 Special Health Care Needs (SHCN) overview and definitions

2023 special health care needs components

SHCN: Full Benefit Dual Eligibles (FBDE) Population

- Required for all CCOs
- Must be planned in partnership with affiliated Medicare Advantage plan(s)
- For CCOs where DSNP is the affiliated Medicare Advantage plan, this project will also meet the Coordination of Benefits Agreement TQS requirement for the DSNP

SHCN: Non-duals Medicaid Population

- Required for all CCOs
- Identify target population within Medicaid-only CCO members with special health care needs –see next slides to assist in identifying your population for your project

SHCN population definition

"Members with SHCN" means individuals with…

At least one of these:

- High health care needs
- Multiple chronic conditions
- Mental illness
- Substance use disorders

AND

At least one of these:

- Have functional disabilities
- Live with health or social conditions that place them at risk of developing functional disabilities
- Prioritized populations as defined in OAR

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2023 SHCN requirements and opportunities for improvement

https://www.oregon.gov/oha/HPA/dsi-tc/Documents/TQS-Scoring-Criteria.pdf

SHCN non-FBDE component requirements

- Identify a population within your **non-FBDE Medicaid members with SHCN**.
- Utilize evidence-based or innovative strategies to ensure your identified population has access to integrated and coordinated care.
    - ✓ Is there evidence that this type of intervention will be effective to achieve your targeted health improvement outcome?
- Primarily focus on quality improvements related to improving health outcomes for your identified SHCN population. Clearly describe how project and activities will achieve targeted short- and long-term health improvements.
- Identify and monitor health outcomes for your identified SHCN population. Clearly define with measurable objectives and activities.

SHCN-FBDE component requirements

- Identify a population within your **FBDE members with SHCN**.
- Utilize evidence-based or innovative strategies to ensure your identified population has access to integrated and coordinated care
  - ✓ Is there evidence that this type of intervention will be effective to achieve your targeted health improvement outcome?
- Primarily focus on quality improvements related to improving health outcomes for your identified SHCN population. Clearly describe how project and activities will achieve targeted short- and long-term health improvements.
- Identify and monitor health outcomes for your identified SHCN population. Clearly define with measurable objectives and activities.
- **Include clear collaboration with your affiliated MA plan.**

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Tips for SHCN projects

- Project must focus on innovative approaches to improve health outcomes in SCHN populations.
- If the project only addresses underlying social factors, member surveys, access to services or reductions in cost/expenditures — and not health outcomes — it will not meet the SCHN TQS component requirement.
- If you've attached additional components to your project, you still must meet all SHCN requirements.
- Ensure project narrative, rationale and activities clearly describe how they will achieve targeted health improvement. Ensure you have selected appropriate health variables to showcase targeted short- and long-range health improvements.

Alignment opportunities with CCO contract

- ✓ Produce a treatment or service plan for members with SHCN that are determined through assessment to need a course of treatment or regular care monitoring, and ICCP plans as indicated. Examples:
  - ✓ Data on care/treatment plans developed and shared with all providers, or in IDT meetings
  - ✓ Care plans reassessed/updated at minimum regularly every 90 days
- ✓ Coordinate services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays that reduce duplication of assessment and care planning activities as outlined in OAR 410-141-3860.
  - ✓ All medications, DME, treatment plans, follow-up appts, LTSS assessments, scheduled before discharge
  - ✓ Tracking THW visits post-discharge/transition
  - Tracking readmissions or unnecessary ER or hospital stays

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Ways to improve outcome measures and data

- Include measurable short- **and** long-term activities and monitoring measures
- Consider which data elements align with tracking needs to ensure project is being implemented (short-term outcomes)
- Consider available sources of outcome data
- Consider CCO improvement efforts for core CCO metrics
- For projects that include FBDE members, consider Medicare metrics your partner MA/DSNP is tracking

What is important to SCHN TQS projects?

Examples of key variables that document (1) the improvement project is being implemented as designed **and** (2) those variables that showcase health improvement. Projects should set measurement targets for variables.

Process evaluation (short–term monitoring)

- Tracking referrals
- Tracking attendance at follow-up appts
- Discharge documents delivered to providers post-discharge
- Medication fills
- Providers document screenings
- Treatment plans are developed and updated
- Utilization of services

Outcome evaluation (long-term monitoring)

- Tracking health care improvements:
  - Hemoglobin A1c
  - Blood pressure
- Tracking metrics improvements:
  - Reductions in hospital readmissions
  - Avoidable ED use
  - ED disparity metric for SMI
  - PQI 05: COPD or asthma in older adult admission rate
  - PQI 08: congestive heart failure admission rate

LOOK AT EXAMPLE STRATEGICS DOCUMENT!

Please read the sample SHCN projects in the TQS Example Strategies to see types of measurable activities necessary for a successful SHCN quality improvement project.

OHA expects clearly written measurable (SMART/SMARTIE) short- and long-term monitoring activities that include identified health variable tracking.

Ensure your data and project rationale are clearly connected to your project and your targeted health improvements.

https://www.oregon.gov/oha/HPA/dsi-tc/Documents/TQS-Example-Strategies.pdf

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Facilitated Q&A: health outcomes, measurement examples, etc.

Q: How do I develop a SCHN project to ensure a monitoring program for the SCHN population?

Q: What are good examples of long-term health care improvement metrics, and why doesn't MEPP data count?

Q: What are good examples of short-term monitoring measures and appropriately paired long-term monitoring measures?

Q: How does a project link the identified gap, activities and metrics? How does a CCO begin and build a cohesive rationale and project from start to measures for short- and long-term outcomes?

2023 TQS technical assistance

Guidance documents: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

Webinar series (October–December)

- ✓ Webinars include general and component-specific lessons learned, changes for the coming year and time for CCOs to ask OHA SMEs questions.
- ✓ Focus: Utilization review/MEPP; SPMI; SHCN; REALD data; SMARTIE goals

Office hours (November–March)

- ✓ Allows CCOs to ask questions as they develop and finalize their TQS submissions.
- ✓ Offered monthly (first Thursdays).

Feedback on sample project (February)

- ✓ Each CCO may submit one project for feedback prior to final submission (due Feb. 15).

Written and oral feedback for each CCO (early summer)

- ✓ Feedback on strengths and weaknesses in documentation or structure of CCO health transformation and quality work.
- ✓ Written assessment with scores; required 60-minute call with OHA.

Q & A

Reference: Additional measurement examples

Example monitoring measures for LTSS

Short-term monitoring measures:

- # of APD/AAA referrals to CCO for ICC review [Monthly/Year Total]
- # of members with LTSS that are addressed/staffed via IDT meetings monthly [Monthly/Year Total]
- % of CCO person-centered care plans for members with LTSS that are updated at least every 90 days/quarterly and shared with all relevant parties [Annual]
- % transitions where discharge orders (DME, medications, transportation) were arranged prior to discharge/did not delay discharge [Monthly/Year]
- # of CCO Collective Platform HEN notifications monthly result in follow-up or consultation with APD/AAA teams for members with LTSS or new in-need of LTSS assessments [Monthly/Year]

Long-term monitoring measures:

- Statewide quality metric for CCO: All-cause readmissions
- Statewide quality metric for CCO: Ambulatory care: Avoidable emergency department utilization
- CCO incentive metric: Screening for depression and follow-up plan
- Other metrics (select any that apply) such as the disparity measure: emergency department utilization among members with mental illness

Short-term monitoring measures:

Members with diabetes and SMI/SPMI

Monitoring measure: Improvements in core care management goals of SMI/SPMI and diabetes type II case management cohort are tracked to review team performance in creating access and follow-up as envisioned.

Baseline or current state	Target/future state	Target met by	Benchmark/future state	Benchmark met by
Use of Hospital Event notifications triggers provides opportunity for direct follow-up on any ED utilization or hospitalization for cohort members	For 75% of cohort, CHW ensures follow-up appointments scheduled post ED visit with primary care, specialist and/or behavioral health as soon as possible and providers receive discharge plans within 48 hours of ED or hospital discharge	8/30/2022	90% of cohort attend follow-up appointments for primary care and/or behavioral health within two weeks of ED visits and providers receive ED or hospital discharge plans within 24 hours.	09/2023

Baseline or current state	Target/future state	Target met by	Benchmark/future state	Benchmark met by
Cohort members receive depression screening within 4 months of selection to cohort	60% Primary care providers for identified cohort create flags to ensure members receive depression screening	6/30/2022	80% of primary care providers have system flags and can report to CCO on status of depression screening quarterly	12/30/2022

Long-term monitoring measures:

Members with diabetes and SMI/SPMI

Monitoring measure: Track longer-term health and outcome metrics for diabetes/SMI cohort population for two years.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
Reduce avoidable/unnecessary ED visits for cohort population	Reduce ED visits in targeted population by 70%	6/30/2022	Reduce ED visits overall for all diabetics and all SMI population by 50%	12/31/2023
Targeted population has improved Hemoglobin A1C control	80% of targeted population has improvement in A1C values	12/31/2022	CCO sees all Diabetics and SMI members have improved A1C values. [Target improvement 85%]	12/31/2023
Targeted population has improved medication adherence Develop Baseline data on correlation of medication refills and ED visits	Cohort improves regular medication compliance from Q1 to Q4. Complete report on correlation of medication refills and ED visits	12/31/2022	Improve medication adherence in cohort population and all diabetics and SMI population by 20%. Continue to track correlation of medication refills and ED visits with target of 15% improvement annually	12/31/2023

Resources

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OHA TQS leads:

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All TQS resources, including the templates, guidance document, and technical assistance schedule are available on the **Transformation Center website**: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

The templates and guidance document are also cross-posted on the **CCO Contract Forms page**: www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

Thank You

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