2021 Transformation and Quality Strategy: Special Health Care Needs

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Oregon Health Authority

Webinar agenda

1. Component overview and definitions
2. Component requirements and scoring criteria
3. Tips and examples
4. Q & A

Why we do this work…

To support the safe and high-quality care for all members under CCOs by ensuring the quality and transformation plan adequately covers federal requirements, pushes health transformation forward, and continues the path towards the triple aim (better care, better health, lower cost).

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2021 components

1	Access: Quality and Adequacy of Services	**9**	Oral Health Integration
2	Access: Cultural Considerations	**10**	Patient-Centered Primary Care Home (PCPCH): Member Enrollment
3	Access: Timely	**11**	PCPCH: Tier Advancement
4	Behavioral Health Integration	**12**	Severe and Persistent Mental Illness (SPMI)
5	CLAS Standards	**13**	Social Determinants of Health & Equity
6	Grievance and Appeal System	**14**	Special Health Care Needs (SHCN)
7	Health Equity: Data	**15**	Utilization Review
8	Health Equity: Cultural Responsiveness		

2020 TQS SHCN OVERVIEW

By the numbers

- Average # of SHCN projects per CCO = **1.36**
- Percent* of SHCN projects continued from prior year = **47%**
- Average score (out of 3) = **1.85**

**Does not include new CCOs as of 2020*

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SHCN COMPONENT OVERVIEW AND DEFINITIONS

SHCN population definition

"Members with SHCN" means individuals who have high health care needs, multiple chronic conditions, mental illness or substance use disorders **and** either:

1) Have functional disabilities; **OR**
2) Live with health or social conditions that place them at risk of developing functional disabilities; **OR**
3) SCHN populations as defined in OAR; see slide 9-10 for details

Prioritized population definition

Includes the following:

- Individuals with SPMI
- Individuals at risk of first episode psychosis
- Individuals within the I/DD population
- Individuals in Medication Assisted Treatment for SUD
- Intravenous drug users
- Individuals with SUD in need of withdrawal management
- Individuals with HIV/AIDS
- Individuals with tuberculosis
- Children 0-5 at risk of maltreatment
- Children showing early signs of social/emotional or behavioral problems and/or have a SED diagnosis
- Children with neonatal abstinence syndrome
- Children in Child Welfare
- Pregnant women and parents with dependent children
- Veterans and their families
- Other prioritized members

CCO Contract: Sec. 2 and 10 of Ex. B, Part 4. and, as provided for under OAR 410-141-3220

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Additional SHCN populations by OAR or contract

Members of ICC prioritized populations: Intensive care coordination prioritized populations include individuals who

a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;

b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are receiving Medicaid-funded long-term care services and supports (LTSS).

CCO Contract: Sec. 10 of Ex. B, Part 4 and OAR 410-141-3870

Members with long-term services and supports: Contractor shall implement mechanisms to assess members receiving long-term services and supports to identify any ongoing special conditions that require a course of physical health services, behavioral health services or care management, or any combination thereof.

CCO Contract Exhibit B – Statement of Work – Part 4 – Providers and Delivery System, Access to Care

SHCN COMPONENT REQUIREMENTS AND SCORING CRITERIA

TQS SHCN project requirements

Projects must do the following (basis of scoring):

- Ensure SHCN members have access to appropriate care and care coordination, development of treatment plan or care transition processes;
- Utilize evidence-based or innovative strategies to ensure access to integrated and coordinated care;

TQS SHCN project requirements

Projects must do the following (basis of scoring):

- Primarily focus on quality improvements related to improving health outcomes for an identified population of SHCN members that meets the SHCN definition; and
- Identify and monitor health outcomes for prioritized populations. If the project addresses underlying social factors only and not health outcomes, it will not meet this TQS component requirement.

FBDE with special health care needs

CMS strongly supports increased integrated care for full benefit dual eligible (FBDE) members in CCOs and their affiliated/contracted Medicare Advantage (MA) plan or MA Dual-Eligible Special Needs Plan (DSNP).

- This provides an opportunity to address cross-system collaborative quality improvement to impact FBDE members with special health care needs who may currently not have access to integrated, coordinated or seamless processes with the MA/DSNP and other partners to meet new CCO 2.0 goals.

- DSNPs are required since contract year 2020 to partner with their affiliated CCOs to implement a shared quality improvement project(s) for a specific FBDE duals population with special health care needs.

DSNP – CCO TQS project

If your CCO has a DSNP contract, CCOs have two options:

1. CCO may submit your required QI project focused on FBDE members (in partnership with affiliated/contracted DSNPs) through the TQS as a SHCN project.
   a) This project will be reviewed and scored as a TQS project.
   b) You will be required to submit a second SHCN project focused on a non-FBDE duals population.

2. CCO may also choose not to submit your required FBDE project through the TQS.
   a) CCO will still be responsible for the requirement to have a shared QI project.
   b) CCO will not be penalized for not submitting it through the TQS.

SHCN TIPS AND EXAMPLES

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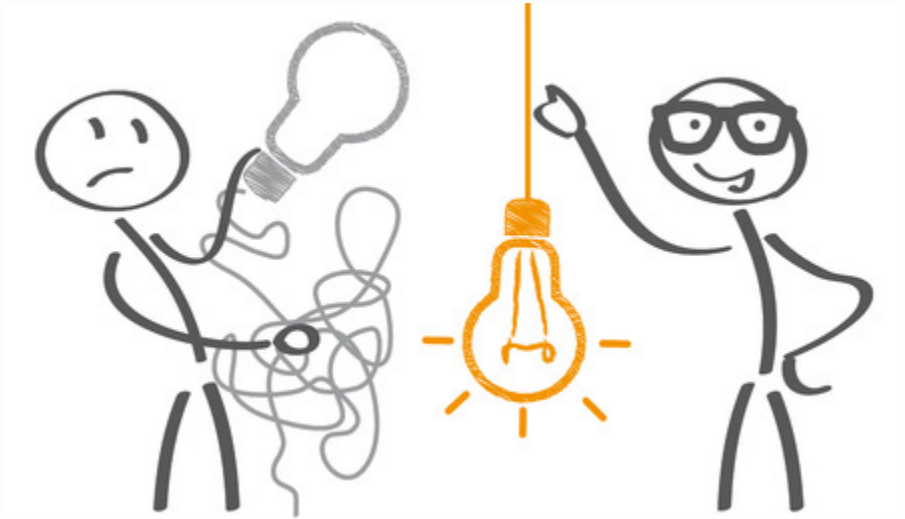
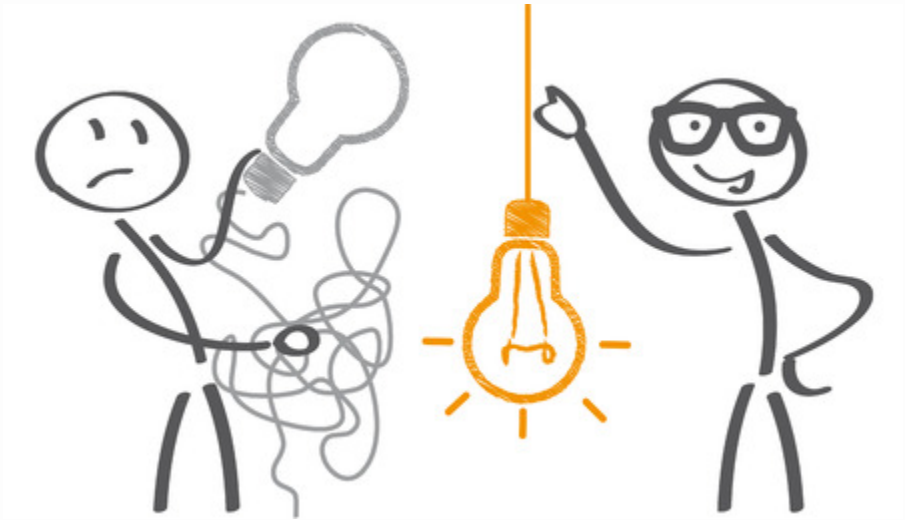
Alignment opportunities with CCO contract

- ✓ Monitor the mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs.
- ✓ Ensure each member with SHCN has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member.



Alignment opportunities with CCO contract

- ✓ Produce a treatment or service plan for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring, and ICCP Plans as indicated.
- ✓ 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.



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Ways to improve outcome measures and data

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

SCHN project examples

The next few slides are meant to highlight key project areas that are critical to ensure alignment with scoring criteria:

- ✓ Strong Project Rationale
- ✓ Strong Project Description
- ✓ Short-term Monitoring Activities
- ✓ Long-term Monitoring Activities

A project should clearly identify and monitor health outcomes for prioritized SHCN populations.

SCHN project with strong rationale

Background and rationale/justification: **One-third of children entering foster care have a chronic health condition and up to 80% have a significant mental health need. Adolescents in foster care are more likely to engage in risk taking behaviors than their non-foster peers and are 2.5 times more likely to experience pregnancy by age 19.** Substance use is higher, and these youths tend to have a poorer social support system. They are more likely to have an ACE score of 4 or higher. They are more likely to have a diagnosis of ADD, PTSD, depression, use tobacco and have asthma. Even when the child is no longer in foster care, many of these health conditions remain at rates higher than non-foster children. The current American Academy of Pediatrics (AAP) recommendation is that all children entering foster care have a health screening within 72 hours of placement with medically complex children receiving care within 24 hours, and all children in care a comprehensive health assessment at or around 30 days after placement in care. The AAP classifies children in foster care as children with special health care needs (CYSHN), requiring more frequent medical visits and [illegible] foster families struggle to have the children seen in a timely manner, the care is often fragmented and mental health assessments challenging to complete. Pediatricians have 20 to 30 minutes to see children who often have complex needs and medical history that is often incomplete.

Coordinating care for a child in foster care is often complex and challenging. Transitions back to the biological family, or when children age out of the foster system, are critical times for on-going case management.

Data included to justify project!

Problem statement included!

Project aligns Outcome Monitoring Activity to improve the CCO Incentive Metric Assessments for Children in DHS Custody.

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Health information exchange and SHCN

Project or program brief narrative description: CCO revamped our diabetes care program in 2018. A key aspect of the revamped program was to incorporate additional health information data into the selection criteria for those members that are deemed to benefit the most from inclusion in the program. **Key data points that were decided upon included A1C test results (QRDA1 type data), MARA predictive risk scores, and inpatient and emergency department utilization with diabetes** as the primary diagnosis. Another feature of the new program is Chronic Case Managers are able to increase member health literacy by providing health education that supports the medical treatment plan that members have developed with their PCP and/or Specialist. In addition, an increase in collaboration is to also take place with the health plan and medical providers. Dental assessments for program enrollees will also be a focus.

Incorporated monitoring of health status data

CCO aligned this project with outcome monitoring activity to improve the CCO metrics in comprehensive diabetes care: hemoglobin A1c (HbA1c) poor control and oral evaluation for adults with diabetes.

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Example monitoring activities for LTSS

Short-term monitoring activities:

- # 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 activities:

- 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 Disparity Measure: Emergency Department Utilization among Members with Mental Illness

Short-term monitoring activities:
ICC population and specialty care

Monitoring activity 1 for improvement: CCO will develop logic and specifications that identify direct access to specialty care services for members within the ICC population.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No current method exists to push lists of ICC-identified members (per 2020 OARs) into the claims	Produce a monthly report of identified ICC members to be loaded into the claims processing	09/2021	Produce a monthly report of identified ICC members to be loaded into the claims processing	09/2021

Monitoring activity 2 for improvement: CCO will create a report for ICC members' utilization of direct access to specialty care services and will use this report to develop strategies in Q1 2021 to increase ICC members' utilization of specialty care services if indicated.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
There are currently no reports on ICC members' utilization of direct access to specialty care.	Establish a report that analyzes ICC members' utilization of direct access to specialty care.	12/2021	Establish a report that analyzes ICC members' utilization of direct access to specialty care.	12/2021

Long-term monitoring activities:
LTC hospital readmissions for members with dementia

Monitoring activity for improvement: Long term care (LTS) and hospital readmission rates for members with dementia.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No standardized HIE transition care planning and discharge transition process for FBDE members with dementia completing transitions of care	Develop standardized HIE transition care planning and discharge transition process for FBDE members with dementia	12/31/2021	Implement standardized HIE transition care planning and discharge transition process for all FBDE members with dementia	12/31/2022
Unnecessary LTC admissions for members with dementia: X%	Reduce LTC admissions by 15%.	12/31/2021	Reduce LTC admissions by 10% over prior year.	12/31/2022
Unnecessary hospital readmissions for members with dementia: X%	Reduce unnecessary hospital readmissions by 15%.	12/31/2021	Reduce unnecessary hospital readmission by 10% over prior year.	12/31/2022

Q&A

- Please unmute yourself to ask questions or type them into the “Chat” box.
- We will update our Frequently Asked Questions document as needed.

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2021 TQS Technical Assistance

- Guidance documents: www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx
- Webinar series (late fall and winter)
  - **Purpose:** The webinars provide technical assistance to aid the CCOs in developing next year's TQS submission.
  - 6-part webinar series that covers general and component-specific lessons learned and changes for the coming year. Webinars include time for CCOs to ask OHA SMEs questions.
- Office hours (winter)
  - **Purpose:** Allows CCO to ask questions as the CCO is developing and finalizing the TQS submission.
- Written and verbal feedback for each CCO (early summer)
  - **Purpose**: Provides CCOs feedback on strengths and weaknesses in documentation or structure of CCO health transformation and quality work.
  - Written assessment with scores; 60-minute call with OHA.

Resources

- **OHA SHCN lead:** Jennifer Valentine: Jennifer.B.Valentine@dhsoha.state.or.us
- **OHA TQS leads:**
  - Lisa Bui: Lisa.T.Bui@dhsoha.state.or.us
  - Anona Gund: Anona.E.Gund@dhsoha.state.or.us
  - Veronica Guerra: Veronica.Guerra@dhsoha.state.or.us
- All TQS resources, including the templates, guidance document, examples and technical assistance schedule are available on the **Transformation Center website**: https://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**: http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx