2022 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
- Component overview and definitions
- Component requirements and scoring criteria
- Tips, examples and resources
- 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
   - ✓ Supports OHA's use of information to monitor CCOs' progress to benchmarks.
   - ✓ Incorporates narrative style and specific/measurement methods.
   - ✓ Combines two annual deliverables from prior years 2012–2017.

Why do the work

Efficiency
is doing things right;

Effectiveness
is doing the *right* things.

– Peter Drucker

2022 TQS components

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

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**	Serious and Persistent Mental Illness (SPMI)
5	CLAS Standards	**13**	Social Determinants of Health & Equity (SDOH-E)
6	Grievance and Appeal System	**14**	Special Health Care Needs (SHCN): Full Benefit Dual Eligible Population*
7	Health Equity: Data	**15**	Special Health Care Needs (SHCN): Non-duals Medicaid Population*
8	Health Equity: Cultural Responsiveness	**16**	Utilization Review

**New for 2022: SCHN is now two components*

2022 SHCN overview and definitions

Important notes for 2022 TQS

- Project submissions are due March 15, 2022.
- Projects with multiple TQS components must meet the component-specific requirements for each component. Failing to meet the component-specific requirements will result in a score of zero with no opportunity to resubmit a corrected version.
- Technical assistance is available prior to submission to answer questions.
- SHCN component-specific notes:
    - All CCOs must submit two separate projects: One for full-benefit dual eligible populations, one for other Medicaid populations
    - Each project must address population with special health care needs **and** target improved health outcomes.
    - The DSNP COBA required project needs to be submitted with aligned CCOs as the FBDE 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 (see slides 11–12 for details)

Prioritized population definition

Includes the following individuals who:

- Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;
- 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);
- Are in medication assisted treatment for SUD;
- Are children ages 0-5
  - Showing early signs of social/emotional or behavioral problems, or
  - Have a Serious Emotional Disorder (SED) diagnosis;
- Are Children in Child Welfare;
- Are IV drug users;
- People with SUD in need of withdrawal management;

CCO Contract: Ex. B, Part 4, Sec. 9 and OAR 410-141-3870

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Prioritized population definition

Includes the following individuals who:

- Are women who have been diagnosed with a high-risk pregnancy;
- Are children with neonatal abstinence syndrome;
- Have HIV/AIDS or have tuberculosis;
- Are veterans and their families; and
- Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

CCO Contract: Ex. B, Part 4, Sec. 9 and OAR 410-141-3870

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Additional SHCN populations by CCO contract

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, Part 4, Sec 2(g) Providers and Delivery System, Access to Care

2022 SHCN requirements and scoring criteria

2022 special health care needs components

SHCN: Full Benefit Dual Eligibles Population

- Required for all CCOs
- Should 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

TQS SHCN project requirements

Projects must do the following (basis of SHCN relevance 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;
- ✓ Primarily focus on quality improvements related to improving health outcomes for an identified population of SHCN members that meets the SHCN definition. If the project addresses underlying social factors or access to health care services only and not health outcomes, it will not meet this TQS component requirement.

Additional opportunities for SHCN

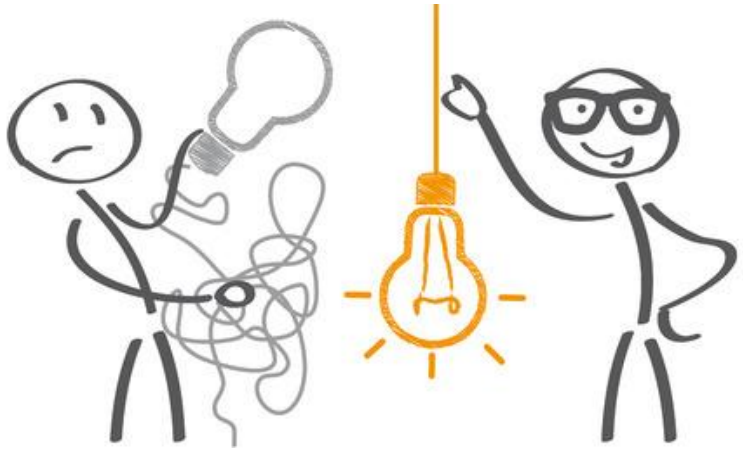
Related to detail and feasibility scoring:

- ✓ Include a clear rationale or justification for selecting the SHCN project, including data that demonstrate the selected intervention is data-driven or evidence-based.
- ✓ All activities should be written as specific, measurable, achievable, realistic and time-bound (SMART).
- ✓ Identify the data, indicator or process measure your CCO will use to assess improvement in the target population as a result of the planned activities.
- ✓ Include monitoring activities that track health outcomes.

SHCN tips and examples

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.
- ✓ Reduce unnecessary hospitalizations or emergency room use
- ✓ 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.
- ✓ Make improvements in care resulting in improved health care outcomes for those with chronic health care needs or disabilities



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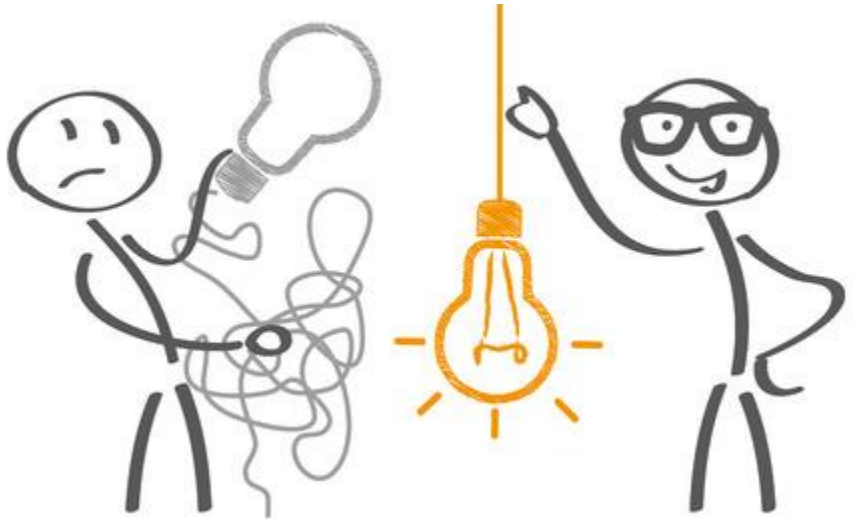
Alignment opportunities with CCO contract

- ✓ 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.



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 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 measures
- ✓ Long-term monitoring measures

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

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

Connecting rationale to project goals

Rationale should describe the evidence for why the intervention your CCO has chosen are likely to result in the health improvement you are proposing. Use your own CCO data and highlight any research data that connects the intervention to outcomes in your narrative sections.

Process/implementation evaluation determines whether program activities have been implemented as intended. Short-term monitoring measures can showcase that you are implementing and achieving steps you outlined in your rationale as the way you will get from current to desired state. The data being tracked can tell whether the project was implemented as intended.

Outcome/effectiveness evaluation measures program effects in the target population by assessing the progress in the outcomes or outcome objectives that the program is to achieve. Did we get the outcomes anticipated? Did we make an impact on health of the targeted population.

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.** Sub[illegible]ce use is higher, and these youths tend to have a poorer social support system. They [illegible] or higher. They are more likely to have a diagnosis of ADD, PTSD, [illegible]a. Even when the child is no longer in foster care, many of these health [illegible]-foster children. The current American Academy of Pediatrics (AAP) [illegible]ng 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 care-coordination. Currently, 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 health education that supports the medical treatment plan that PCP and/or Specialist. In addition, an increase in collaboration is to 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.

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

Short-term monitoring measures:

ICC population and specialty care

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

Baseline or current state	Target/future state	Target met by	Benchmark/future state	Benchmark met by
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	03/15/2022	Implemented outreach activities to members produce increased utilization of specialty care appointments for targeted health populations	12/30/2022

Monitoring measure: CCO will monitor 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 and monitor correlation with ED visits for targeted population.

Baseline or current state	Target/future state	Target met by	Benchmark/future state	Benchmark met by
New report analyzes ICC members' utilization of direct access to specialty care.	See improvement in utilization of specialty care for targeted ICC members from Q1 to Q4	12/2022	Document correlations in ICC members receiving regular specialty care visits with reduced unnecessary ED visits	12/2023

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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

Long-term monitoring measures:

LTC hospital readmissions for members with dementia

Monitoring measure: Long-term care (LTC) and hospital readmission rates for members with dementia.

Baseline or current state	Target / future state	Target met by	Benchmark / future state	Benchmark met by
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 –80% of target group will have documented process	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

2022 TQS technical assistance

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

Webinar series (October–November)

- ✓ **Purpose:** Provides technical assistance to CCOs for developing next year's TQS submission.
- ✓ 5-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 (November–March)

- ✓ **Purpose:** Allows CCO to ask questions as the CCO is developing and finalizing the TQS submission.
- ✓ Offered monthly until submission

Written and oral 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; optional 60-minute call with OHA.

Q & A

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, 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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