2024 Transformation and Quality Strategy (TQS):

Special Health Care Needs

February 21, 2024

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Housekeeping

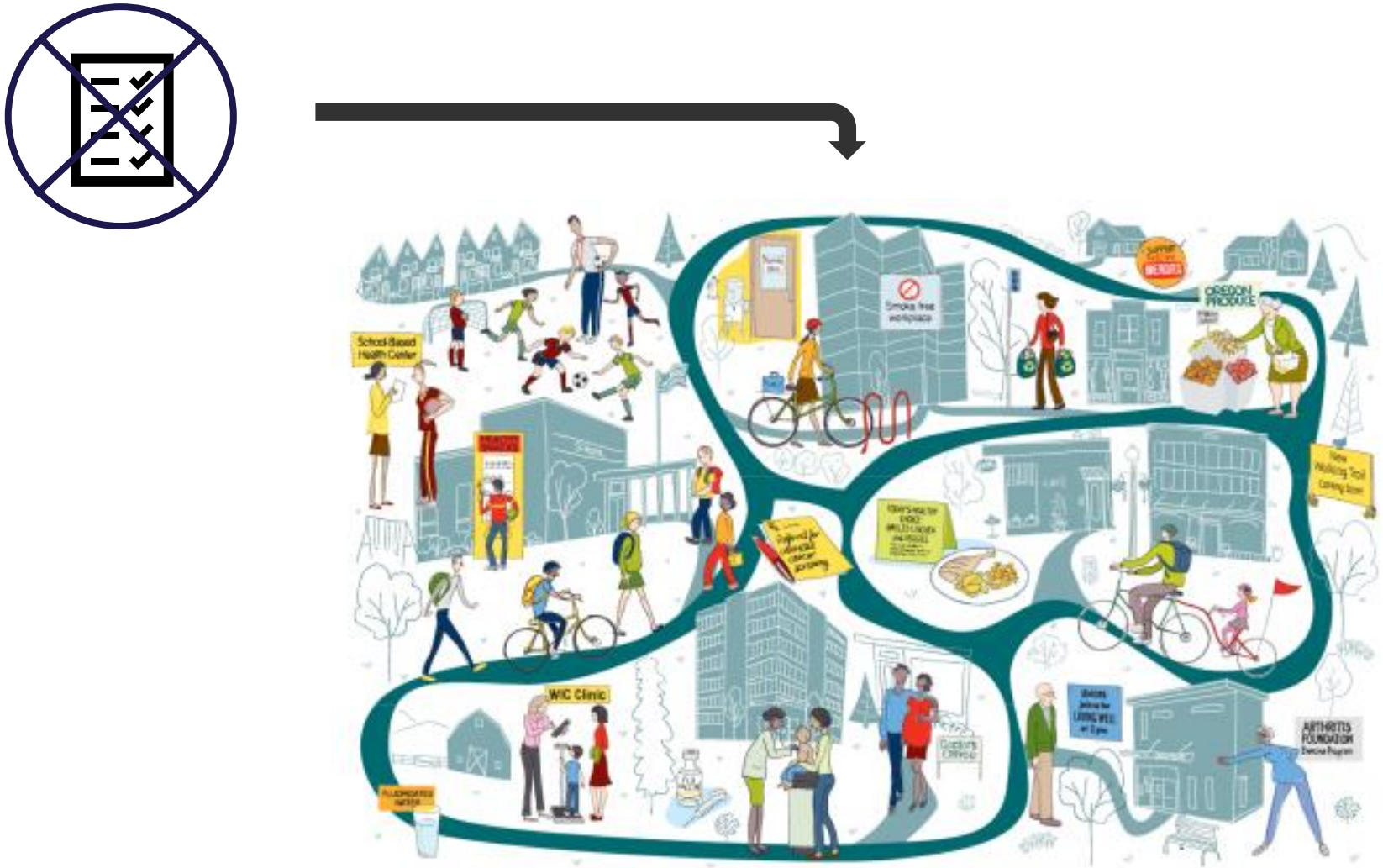
- Please keep yourself on mute when you're not speaking.
- Type questions into the chat at any time.
- This webinar is being recorded. The slides and recording will be available on the Transformation Center TQS TA webpage.

Agenda

- TQS background – 2 min
- SHCN component overview and definitions – 5 min
  - SHCN: Full Benefit Dual Eligible Population
  - SHCN: Non-duals Medicaid Population
- SHCN requirements and opportunities for improvement – 10 min
- Breakouts - 15
- Discussion/Q&A - 15

TQS background

Why do the work



Efficiency
is doing things right;

Effectiveness
is doing the *right* things.

– Peter Drucker

2024 TQS components

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

1. Behavioral Health Integration
2. CLAS Standards
3. Health Equity: Cultural Responsiveness
4. Oral Health Integration
5. Patient-Centered Primary Care Home (PCPCH): Member Enrollment
6. PCPCH: Tier Advancement
7. Serious and Persistent Mental Illness (SPMI)
8. Special Health Care Needs (SHCN): Full Benefit Dual Eligible Population
9. SHCN: Non-duals Medicaid Population

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2024 Special Health Care Needs (SHCN) overview and definitions

Special health care needs components

SHCN: Full Benefit Dual Eligible (FBDE) Population

- Required for all CCOs
- Must be planned in partnership with affiliated Medicare Advantage plan(s)
- For CCOs where DSNP (dual special needs plan) 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

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

Definition updated in OAR 410-141-3500 effective 2/1/2024

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SHCN component requirements

1. **Identify a population with SHCN**.
2. **Utilize evidence-based or innovative strategies** to ensure your identified population has access to integrated and coordinated care.
3. **Primarily focus on quality improvements related to improving health outcomes** for your identified SHCN population.
4. **Identify and monitor health outcomes for your identified SHCN population.**
   - ✓ Include both short-term and long-term health monitoring.
   - ✓ Include REALD and SOGI monitoring.
5. (For FBDE project only) **Include clear collaboration with your affiliated MA plan.**

Opportunities for improvement

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

Write to member health outcomes

SHCN projects must document improvement in health status.

- Don’t stop at process measures – track the right data to show actions are improving member health.
- Pick performance measures focused on health improvement outcomes.
- Include both short- and long-term metrics.
  - Can use existing CCO data to do this work.
  - Also consider what Medicare metrics your DSNP or MA partner is tracking (for FBDE population) for your SCHN-duals project
- Track all member-level data by REALD & GI categories to track gaps in health improvement outcomes and identify disparities.

Examples of short- and long-term health monitoring measures

	Short-term health monitoring measures	Long-term heath outcome measures
Diabetes	• A1C testing/monitoring • Diabetic medication refills • Participation in diabetes self-management programs • Regular primary care visits	• Hemoglobin A1C control • Avoidable emergency department visits
Mental illness	• Discharge planning documents are being shared with all providers • Referral and follow-up to appointments to manage chronic conditions • Medication refills • Regular behavioral health provider visits or documented peer services	• Emergency department visits among members with mental illness • Hospitalization rate among members with SPMI

Examples (slide 2 of 3)

	Short-term health monitoring measures	Long-term heath outcome measures
Asthma	• Primary care visits • Medication refills and management • Home visits for environmental trigger remediation	• Hospital admissions • Readmissions • Avoidable emergency department visits
Dementia	• Depression screening by primary care providers for members with dementia diagnosis • Health information exchange workflow for dementia care coordination and planning • Integrated care plans • Medication reconciliation	• Unnecessary emergency department admission for members with dementia

Examples (3 of 3)

	Short-term health monitoring measures	Long-term heath outcome measures
Falls	• Medication reconciliation and review • Medication therapy management program participation • Home visits for safety review/homes receiving safety modifications like new exterior stair railings or ramps • Participation in/completion of falls prevention programs	• Fall rate • Hospitalizations for falls

Make sure you can track the data by REALD & SOGI. Examples:

- Track A1C testing by REALD & SOGI to ensure there is equitable access.
- If avoidable hospital visits for diabetes are significantly higher for certain groups, add targeted activities to reduce gaps.

Discussion: choosing metrics to track health outcomes

Instructions

1. Review a project scenario (on slide).
2. Break into small groups.
3. Small-group discussion: Which of the metric options would be the most effective?
    - Choose 1–2 you'd select for the project.
4. Large-group discussion

FBDE population scenario

Population: Dual Eligible members with diabetes

Gap being addressed: Preventable complications of diabetes. Latino, Vietnamese and Chinese Medicare/Medicaid dual members with diabetes have poorer health outcomes, A1C testing compliance, medication adherence.

Project/intervention: Decrease preventable diabetes complication. Increase diabetic patient ability to self-manage diabetes by increasing enrollment and completion in Chronic Disease Self-Management programs for Diabetes. Offer classes in more languages on a regular schedule.

FBDE population scenario: Measures

1. Track goal to increase diabetic members receiving quarterly primary care visits with minimum twice per year A1C testing and 4 x per year in-office BP checks by 12/2024.	2. Track office visits and A1C by claims data and sort by REALD and SOGI to identify any disparities in care model targets by 12/2024 and 12/2025.	3. Track how many case managers and RNs from primary care offices complete chronic conditions case management and motivational interviewing training.
4. Track Medicare Advantage metrics improvement for Dual Eligible members enrolled in partner MA or DSNP plan (e.g., increase HEDIS CDC- BP control by 35% to 43.8% [NCQA 5th percentile] by 12/31/2024).	5. Track enrollment and completion of Diabetes Self-Management classes for non-English speaking CCO members in their own language (especially targeting increase by 30% for Spanish-, Chinese- and Vietnamese- speaking populations by 12/2024.)	6. Increase percentage of diabetic patients completing Diabetes Self-Management classes by 20% by 12/2024 and 40% by 12/2025 as measured by tracking of electronic referrals to classes to determine if process for referrals and member engagement are effective.
7. Track medication refill data by REALD and SOGI to identify any disparities in regular refill in medication compliance regiments by 12/2024 and 12/2025.	8. New flyer developed and sent to highlight the Diabetes Self-Management class offerings by 12/2024 and online registration access point created on website by 8/2024.	9. PQI 01: Diabetes short-term complication admission rate: Decrease diabetic short term complication rate by 10% by 12/2024 and 25% by 12/2025.

2024 TQS technical assistance

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

Webinar series (February)

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

Office hours (March–June)

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

Feedback on sample project (June)

- ✓ Each CCO may submit one project for feedback prior to final submission (due June 15, but the earlier the better).

Written and oral feedback for each CCO (by Aug 30)

- ✓ Feedback on strengths and weaknesses in documentation or structure of CCO health transformation and quality work.
- ✓ Written assessment with scores by Aug. 30; optional feedback 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	8/30/2024	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; monitor READLD/SOGI to ensure no gap in equitable access and follow-up	09/2025
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	6/30/2024	80% of primary care providers have system flags and can report to CCO on status of depression screening quarterly Track equitable access to depression screening completion through claims by READLD/SOGI by 12/2025	12/30/2024

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%	6/30/2024 ★	Reduce ED visits overall for all diabetics and all SMI population by 50%; use REALD and SOGI data to ensure equitable improvement in metrics/outcomes	12/31/2025
Targeted population has improved Hemoglobin A1C control with 25% improvement	80% of targeted population has improvement in A1C values	12/31/2024	CCO sees all Diabetics and SMI members have improved A1C values. [track improvement by REALD and SOGI to ensure no gaps]	12/31/2025
Targeted population has improved medication adherence Develop Baseline data on correlation of medication refills and ED visits, identify any gaps by REALD and SOGI and implement any unique outreach to reduce disparities.	Cohort improves regular medication compliance from Q1 to Q4. Complete report on correlation of medication refills and ED visits	12/31/2024	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; reduction of identified disparities by 50% by monitoring REALD/SOGI	12/31/2025

Resources

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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