Example Transformation and Quality Strategy (TQS)

This document provides examples of potential TQS strategies addressing various TQS components. It is meant to be a tool, and it doesn't include an example for every component. The level of detail needed will vary for each specific project or program your CCO submits, depending on the component(s) it addresses, the type of project or program it is, its stage of implementation, etc.

Contents

Section 1: Transformation and Quality Program Information

A. CCO governance and program structure for quality and transformation:

i. Describe your CCO's quality program structure, including your process for developing and implementing your TQS:

ExampleCCO is a coordinated care organization (CCO) that provides services to Oregon Health Plan (OHP) members in accordance with the laws, rules, regulations and contractual requirements that apply to the Oregon Health Plan.

The current structure of ExampleCCO supports innovation and quality at the local level. The board of directors is accountable for all operations of the CCO. Multiple stakeholders and community leadership are part of the ExampleCCO's board and community advisory council (CAC). The connection between the board and CAC are through co-sitting roles of CCO chief medical officer and board president. The board and CAC provide ExampleCCO guidance on how to address community, patient and delivery system needs and priorities. Development of the TQS is an iterative process with the quality improvement committee (QIC), board and CAC based upon a multitude of data reports and work plan updates throughout the year. At a minimum, the board meets bi-monthly and the CAC meets quarterly. Regular connections to the board chair and CAC leadership is also available. Ultimately, our chief medical officer is accountable for ensuring the high quality of care and service delivery.

ExampleCCO's QIC provides oversight for quality assurance and performance improvement activities to ensure that CCO members receive high-quality, culturally and linguistically appropriate physical, behavioral and dental care and services. This multi-disciplinary committee is a decision-making body that has the authority and representation to develop and implement integrated quality improvement activities with the goal of advancing the triple aim for ExampleCCO members. Our medical director oversees the QIC and reports committee activities to the board of directors. The QIC consists of operational leaders in health promotion, dental care, credentialing, Medicaid services, health equity, quality assurance and other decision-making representatives (for example, regional advisory council representatives). Additional committees within ExampleCCO that are relevant to health transformation and quality are: the utilization review committee, the clinical advisory panel, the grievance committee, and the care coordination committee. Each of these individual committees regularly reports to the QIC.

Throughout the year, the QIC also reviews the developed work plans from the TQS to monitor progress. Additionally, the QIC is responsible for the overall submission of the annual TQS; which is used to move health transformation and implement and ensure quality, culturally and linguistically appropriate, and coordinated health care, including behavioral health and dental care. ExampleCCO's medical director and quality director present the annual TQS to ExampleCCO's board of directors for adoption.

ii. Describe how your CCO uses its community health improvement plan as part of its strategic planning process for transformation and quality:

The regional CAC (RCAC) coordinator and chair, and each LCAC coordinator and chair, oversee the development, adoption and implementation of ExampleCCO's community health improvement plan (CHP). The RCAC representation on the QIC ensures alignment with CHP implementation strategies by highlighting strategies that support the current CHP health priorities, sharing current CHP strategies being implemented by ExampleCCO and/or the CHP's other key stakeholders, and providing updates on CHP health priority metrics. Additionally, the QIC shares the annual TQS with the RCAC, and annually presents an update on TQS progress.

iii. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the TQS:
As a partner in the community, ExampleCCO believes in a bi-directional relationship to further our community's health. ExampleCCO works with community systems for delivery of care, communication and engagement with members, strategic planning insights, and the development of cross-agency initiatives to improve the health of our community. For example, ExampleCCO works with the local public health WIC program, community-based organizations for maternal health, and the two community health centers who provide XX% of maternal care in XX county/ExampleCCO region. Additional details of areas of cross collaboration are in section II by component area.

B. OPTIONAL

i. Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS:
No specific example provided; of note this optional information is for providing OHA the context of regional priorities, CCO strategic approach and connection to quality, geographic regions and limitations, and enrollment demographics.

Section 2: Transformation and Quality Program Details

A. **Project or program short title**: Project 1: Improving utilization of language access services in behavioral health settings

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Utilization review
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. **Background and rationale/justification**:

Use of language access services by CCO behavioral health (BH) providers' offices has been stable over the past four years. The average rate of requests for language assistance was 2.5 per clinic per quarter. However, the percent of members enrolled in the CCO whose primary language is identified as not English increased 25% over the last two years and there has been a slight decrease in the BH utilization rates in the last four years.

D. **Project or program brief narrative description**:

The ExampleCCO QIC will coordinate with behavioral health contractors and subcontractors to analyze language access service utilization rates for CCO members who identify their primary language as not English. The QIC will delegate to the ExampleCCO Quality Management team and ExampleCCO integration team to use data collected to compare utilization rates over time and geographic distribution and investigate whether there is national data available (or comparisons from other states) to establish an appropriate benchmark.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Coordinate with BH contractors and subcontractors to collect data on utilization of language access (including ASL) services by members over the last four years; compare utilization at BH locations with geographic distribution of members and member assignments; investigate national average for utilization and state trends to establish benchmark; make recommendations to QIC based on findings.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Language access services utilization

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2.5/clinic/quarter	TBD	4/2020	TBD	4/2021

A. Project or program short title: Project 2: Increasing maternity care access

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. Components addressed

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. Background and rationale/justification:

Target population: Mother – babies; no specific age group defined.

Key community Stakeholders: Local Public health, WIC, Two primary care practices, one women's health clinic.

Evaluation Analysis: When reviewing our CCO client demographics, maternal and infant health contributes to XX% of our total membership. Connecting women early in their maternity care will improve health outcomes for the infant and provide women in our community with ease of access that meets their needs for right care at right door.

ExampleCCO will do this by utilizing population health data with a health equity lens and segmenting by region (county), age groupings, race, ethnicity, and service delivery, and language (and disability where data available). Program will be developed that will address gaps in care for maternal care through access points in local public health WIC sites, three PCPCH sites of Tier 4 practices for ongoing case management.

Allocation of resources to support the program including items aligned with CLAS standards compliance.

Comparison of results with goals and targets by race, ethnicity and language.

Tracking and trending of key indicators.

D. Project or program brief narrative description:

Ensuring women's health of ExampleCCO region is integral to our healthy community. ExampleCCO will build upon maternal health care for ensuring timeliness to prenatal care through increasing maternity care access points in the community

E. Activities and monitoring for performance improvement:

Activity 1 description: Develop monitoring dashboard for maternal health care with health equity data lens

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Metrics and segmentation determined (for example, timeliness to prenatal care, low birth weight)

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Metrics not identified and segmented	Metrics list and segmentation completed	3/2020	Metrics list and segmentation completed	3/2020

Monitoring activity 1 for improvement: Metrics tested and dashboard developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Metrics tested and dashboard developed	No dashboard	Dashboard developed	6/2020	Dashboard developed

Activity 2 description: Determine gaps in care for maternal health and engage

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Two gaps in care prioritized for intervention and work plans developed to address each

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current interventions to address gaps.	Two gaps identified	6/2020	Work plans developed	9/2020

Monitoring activity 2 for improvement: Health outcome metric for each gap identified and improved

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No metric identified	Metric for each gap identified	9/2020	Metric improved by X%	12/2020

Activity 3 description: Develop maternal care team

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Maternal care team identified, trained, and implements intervention

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No maternal care team in place	Maternal care team identified	9/2020	Maternal care team trained and implements intervention	12/2020

Activity 4 description: Develop referral system for identified populations in need of maternal care from WIC sites, community organizations to PCPCH sites.

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Referral system developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No referral system	Referral system developed	12/2020	Referral system developed	12/2020

Monitoring activity 4 for improvement: Referral system tested

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No referral system	Referral system tested	6/2021	Referral system tested	6/2021

Monitoring activity 4 for improvement: Referral system implemented

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No referral system	Referral system implemented	12/2021	Referral system implemented	12/2021

A. **Project or program short title**: Project 3: Assessing wait times for dental care for members with special health care needs

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. **Components addressed**

i. Component 1: Access: Timely
ii. Component 2 (if applicable): Special health care needs
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. **Background and rationale/justification**:

Average wait times for standard dental appointments for CCO members is X weeks. This meets the OAR and contract standard for wait times. This average includes SHCN members. However, the CCO quality team has noted through monitoring of grievances in 2017 that many of the dental access complaints submitted are made by SCHN members. See attached supporting data and CCO policy and procedure on identification and definition of SHCN CCO members

D. **Project or program brief narrative description**:

The ExampleCCO Quality Management (QM) team will coordinate with contractors and subcontractors to analyze wait times for dental care for CCO members who are identified as having special health care needs (SHCN). The CCO QM team will use data collected to compare wait times for standard vs. urgent dental care and emergency department use for dental services over the last five years, compare the length of wait time experienced by SHCN members and non-SHCN members and investigate whether national data is available (or comparisons from other states) to establish appropriate benchmark

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Coordinate with contractors and subcontractors to collect data on dental wait times for last five years. Stratify data by SHCN designation. Investigate national average to establish benchmark and make recommendations to quality improvement committee based on findings of analysis

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Dental care wait times

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
X weeks for standard dental care (all CCO members)	TBD	9/2019	Average wait times for SHCN members is equal to CCO member average ±5%	4/2022
X weeks for standard dental car (SHCN members)	TBD			

A. Project or program short title: Project 4: Using grievance and appeal data to remove barriers for members

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

B. Components addressed

i. Component 1: Grievance and appeal system
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. Background and rationale/justification:

Using grievance and appeal data to identify problem areas is the first step in determining where a deeper look into the data to reveal root causes is needed. While using complaint, NOABD, appeals and hearings disaggregated data can reveal useful information about specific problem areas, the goal is to encourage the reporting of all grievances, and ensure members know their right to appeal, which helps the CCO identify issues that need to be addressed. Once root causes have been identified the work begins to alleviate the barriers and improve services to members.

D. Project or program brief narrative description:

Using grievance and appeal data that has been disaggregated, review the data across all areas – complaints, NOABDs, appeals and hearings – on a monthly basis and determine one specific area to focus on (such as non-emergency medical transportation [NEMT], as this is an area that is visible to the public and in many areas creates a high number of grievances). Determine where the highest number of grievances, NOABDs, appeals and hearings are happening, research root causes and develop processes to alleviate the issues.

E. Activities and monitoring for performance improvement:

Activity 1 description: Review complaints, NOABD, appeals and hearings data to determine first level where high numbers are reported. Drill down using the service code data to determine specific areas that may be seeing higher numbers of grievances. Choose the specific area of concern and work with the quality committee and others to determine root causes.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Identify specific concern and root causes.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Identify area of highest level of grievances, identify patterns (provider/clinic/brokerage), and research root causes	Root cause analysis completed	03/2020	Root cause analysis completed	03/2020

Activity 2 description: Develop processes to remove barriers

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement:

- Identify staff/committees, etc. who will be involved in developing processes to alleviate the barriers.
- Set timelines to develop processes that will be used to alleviate barriers.
- Identify what types of processes are needed for improvement.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Number of current grievances in area identified through monitoring activity 1	Number of grievances reduced by 25%	06/2020	Number of grievances reduced by 50%	12/2020

A. Project or program short title: Project 5: Communication and language assistance services implementation plan

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. Components addressed:

i. Component 1: Health equity: Cultural responsiveness
ii. Component 2 (if applicable): CLAS standards
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. Background and rationale/justification:

As Oregon's population becomes ever more diverse, health care providers serve increasing numbers of members from diverse cultural and linguistic backgrounds. Culture and language play a crucial role in how effectively health services are delivered and received. Issues such as patient activation and engagement, health care literacy and English language proficiency are all factors that providers must consider when providing culturally and linguistically responsive care and services. The provision of quality language services to individuals with limited English proficiency (LEP) and individuals who are Deaf or hard of hearing is a key component of health equity.

There are currently gaps in availability and access to quality health care interpretation, with less than 15% of LEP or Deaf/hard of hearing members accessing a health care interpreter during their appointments.

D. **Project or program brief narrative description**:

Communication and Language Assistance Services Implementation Plan (CLAS Standards 5-8):

CCO will develop a plan that will allow the CCO and our network health care providers to meet the requirements of CLAS Standards 5, 6, 7 and 8:

1. Providing training to CCO staff and In Network Providers on the CCO interpreter services reimbursement policy in accordance with CLAS Standard No. 6.
2. Ensure CCO members are informed of the availability of language assistance services in their primary language, verbally and in writing through a strategic marketing campaign which will include at least communication online, within our handbook and with all significant communication that is sent to members in accordance with CLAS Standard No. 6
3. Ensure network providers and CCO tracks interpreter utilization to meet CCO contractual requirements and include measurement for timely access in accordance with CLAS Standard No. 5.
4. Ensure CCO and network providers provide easy to understand print and multimedia materials and signage in the languages commonly used or anticipated by the populations in the service area in accordance with CLAS Standard No. 8.
5. Ensure CCO and network providers have a continuous training and understanding of the CCO's interpreter services polices and process for existing staff and new staff in accordance with CLAS standard No. 6. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided in accordance with CLAS Standard No. 7.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: This Communication and Language Assistance Services Implementation Plan (CLAS Standards 5-8): is developed based on the CLAS framework along with consumers and community members, in addition to plan and clinic leadership. It includes the allocation of funds for language services and guidance on the provision of such services that include:

- Create a training development plan and an implementation plan for existing and new CCO staff and providers within our network on interpreter services policies and procedures
- Create a training on how to choose and use qualified and/or certified health care interpreters and what to do if there are concerns about quality
- Create a training and toolkit on using telephonic or video interpreting and contracting with agencies that employ qualified/certified interpreters
- Create a training on understanding how to use interpreter services and the different modalities (with the interpreter present or via phone or video) and considering patient/members preferences
- Create a communication plan on how to engage members and provide members information on the right to interpreter services and how to request interpreter services and what to do if interpreter services are denied or the member experiences issues with interpretation
- Create a communication plan for members and providers on the provision of language services at no cost to members and what it means to facilitate timely access
- Create a policy on the utilization of bilingual staff and when it is or is not appropriate
- Create a tool for providers and members to be able to provide feedback on the quality of language services provided by the interpreter

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Plan is developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current plan	Plan is developed	09/2020	Plan is developed	09/2020

Monitoring activity 1 for improvement: Plan is implemented

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current plan	Plan is implemented	03/2021	Plan is implemented	03/2021

Activity 2 description: Monitoring the implementation of the language plan:

- Ensures data on ethnicity, race, language and disability are gathered using REAL-D standards and used to determine special needs and develop appropriate plans and services such as the use of interpreter services, prevalent languages, provider cultural responsiveness training, engagement with community-based organization and recruitment of a workforce that reflects the culture and language of the communities being served.
- Includes the ongoing assessment of characteristics and needs of the population including race/ethnicity, cultural health beliefs and practices, preferred languages, health literacy, vision and hearing limitations and other communication needs.
- Includes interpreter services utilization tracking mechanisms.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Member data is consistently updated or collected in alignment with REAL-D standards – percent of members with complete demographic fields per REAL-D standards.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
30%	75%	12/2020	100%	12/2021

Monitoring activity 2 for improvement: Percent of members who have identified a primary language other than English and have LEP who have accessed a health care interpreter.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
14.2%	75%	12/2020	100%	12/2021

A. Project or program short title: Project 6: Dental care referrals in behavioral health settings

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. Components addressed

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Behavioral health integration
iii. Component 3 (if applicable): Serious and persistent mental illness
iv. Does this include aspects of health information technology? ☐ Yes ☒ No

C. **Background and rationale/justification**:

ExampleCCO has previously addressed issues of integrated care through evidence-based primary protocols to improve care coordination; screening protocols for early identification and intervention with depression and substance abuse; case management for high-need patients; and improving diabetes monitoring for patients with serious and persistent mental illness through participation in the statewide performance improvement process. Additionally, behavioral health professionals have been embedded at two federally qualified health centers and at two school-based health centers, and a fully licensed health psychologist has been embedded in the family practice division of the region's largest community provider of health care services to CCO members. One area that has not shown significant improvement is oral and dental health care integration for members experiencing SPMI. For the target population of members experiencing SPMI, increased dental health preventive services should decrease the downstream need for a volume of additional dental procedures. Currently, less than half of members experiencing SPMI are receiving any preventive dental examination within a 12-month period.

D. **Project or program brief narrative description**:

ExampleCCO will collaborate with stakeholders to develop and employ an oral health questionnaire for behavioral health professionals to assess and refer members experiencing SPMI to appropriate dental health services.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Develop oral health questionnaire to be used by behavioral health professionals.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Oral health questionnaire developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Questionnaire in development	Questionnaire developed	06/2020	Questionnaire developed	06/2020

Activity 2 description: Behavioral health professionals trained in oral health questionnaire use.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: BH professionals trained

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Training in development	Training provided	09/2020	Training provided	09/2020

Activity 3 description: Oral health questionnaire is implemented and used consistently across trained organizations.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: All trained organizations are consistently using the questionnaire based on behavioral health professional annual survey responses.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0% consistent use	75% consistent use	12/2021	100% consistent use	12/2022

Monitoring activity 3 for improvement: Percent of members experiencing SPMI that have received a dental exam from a dental health professional within the past 12 months.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
48%	60%	12/2021	75%	12/2022

A. Project or program short title: Project 7: Social needs screening and referral pilot

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. Components addressed

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No
v. If this component addresses social determinants of health & equity, which domain(s) does it address?

☒ Economic stability
☒ Education
☒ Neighborhood and build environment
☒ Social and community health

C. Background and rationale/justification:

Unmet social needs have a significant impact on health outcomes, and we know OHP members are at increased risk for food insecurity, housing instability and other factors based on income level alone. ExampleDataSource demonstrates that in ExampleCCO's service area, X% of families experience housing instability, X% are enrolled in SNAP or other self-sufficiency programs, and X% experience family violence or trauma. Many clinicians are aware that these social needs exist in their patient population, but specific needs often remain undetected and unaddressed. Integration of social needs screening into ExampleCCO's primary care settings, and connection of patients with needed resources, can impact health outcomes for both individuals and families.

D. Project or program brief narrative description:

Five of ExampleCCO's participating clinics — that voluntarily choose to participate — will implement social needs screening at primary care visits using ExampleTool. This pilot will prioritize families with children under the age of 5, including screening at well-child visits. Screening is intended to identify families in need of community services, and clinic staff will connect families in need with community resources. Resource navigation staffing that is culturally and linguistically appropriate will be added at the clinic level. Longer-term, these staff will be supported by implementation of a community information exchange (CIE) database that enables electronic referrals between health care, public health, oral health, behavioral health, and social service agencies.

E. Activities and monitoring for performance improvement:

Activity 1 description: Initiate screening for social needs of Oregon Health Plan members at five family practice and pediatric clinics, including at all well-child checks for children under age five.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Percentage of identified/designated staff at each participating practice trained to conduct social determinants of health screening and/or make community referrals to meet identified needs.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 staff trained	75% of designated staff trained	9/30/2020	100% of staff trained	12/31/2020

Activity 2 description: For patients who screen positive for unmet social needs through use of ExampleTool, offer a resource summary and track acceptance rate. Health equity data collected on race, ethnicity, language and gender will guide the referral process to ensure referrals are made to culturally and linguistically appropriate services.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Percent of unique families with children under age five who are screened for social needs, as documented in the EHR.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Clinic 1: 0% Clinic 2: 0% Clinic 3: 0% Clinic 4: 0% Clinic 5: 0%	25% for each clinic	6/30/2020	50% for each clinic	12/31/2020

Monitoring activity 2 for improvement: Number of unique families with children under age five who screened positive for one or more social needs and were offered and accepted a community resource summary, by risk strata data.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Baseline 0 until project start	Establish baseline from first 6 months of screening	6/30/20	Establish baseline from first 6 months of screening.	12/31/20

A. **Project or program short title**: Project 8: Behavioral health integration value-based payment (LAN category 2C)

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. **Components addressed**

a. Component 1: Behavioral health integration
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☐ Yes ☒ No
e. If this component addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

C. **Background and rationale/justification**:

Rewarding or penalizing providers based on their performance related to specific quality measures has shown to improve quality and promote integration. In a Lan Category 2C (pay-for-performance) model, providers' pay is tied to

quality. Performance payment is prospective with retrospective reconciliation. This motivates clinicians and institutions to change the way they deliver care to improve health care quality.

A LAN Category 2C payment model supporting behavioral health integration is currently in place to promote integration of medication assisted treatment with eight primary care practices.

D. **Project or program brief narrative description**:

Example CCO will expand the current value-based payment model that pays for performance to ten additional voluntarily participating primary care providers to incorporate medication assisted treatment and achieve benchmarks on process measures.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Participating providers receive enhanced payment if MAT is offered and benchmark is met on length of member engagement in treatment.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Number of participating clinics

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
8 primary care clinics participating	10 additional clinics participating	1/2021	25% of primary care clinics participating	1/2022

A. **Project or program short title**: Project 9: Building collaborative treatment plans for members with dementia in collaboration with affiliated Medicare Advantage DSNP and LTC/LTSS providers

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

B. **Components addressed**

i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Special health care needs
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☒ Yes ☐ No

C. **Background and rationale/justification**:

Full Benefit Dual Eligible (FBDE) members transitioning to home settings have complex needs that require involvement and planning by primary care, specialists, long-term care providers and the CCO and Medicare Advantage DSNP plan. CCO 2.0 goals target created shared care planning for members that ensure elements of quality transition care and follow-up. Medicare prevalence of dementia is about 14.4% overall and Alzheimer's disease accounts for 60-80% of cases. Vascular dementia, which occurs after a stroke, is the second most common dementia type. Care planning needs to address social determinants of health, potential behavioral health side effects members may be experiencing, coordination of home and community supports to ensure successful transition, and family/caregiver wellness.

D. **Project or program brief narrative description**:

The CCO ICC team and Medicare Advantage DSNP care coordination team will coordinate with contractors and subcontractors to analyze processes and care planning formats, checklists and medication reconciliation checklists that can be shared via the regional HIE to reduce duplication and ensure quality and appropriateness of care. A project team has been established to develop a coordinated care planning approach with local dementia specialists, primary care, APD case managers, and the respective CCO and our partner MA plan (for example: Alzheimer's Association Cognitive

Impairment Care Planning Toolkit). The CCO QM team will use data collected to monitor readmissions and hospitalizations, as well as completion of follow-up monitoring tasks and appointments within the initial 30 days post-transition. The goal is to reduce hospitalizations and hospital readmissions, and improve care referrals, coordination, and information sharing among all care team members.

E. **Activities and monitoring for performance improvement**:

Activity 1 description: Coordinate with Medicare and Medicaid providers/care coordinators, Part D Medication Management teams, and DHS LTSS programs as necessary to implement the established coordinated cognitive impairment care planning approach for comprehensive assessment and coordination of dementia care. This includes HIE implementation to support the coordinated care planning approach and establishing an HIE workflow.

☒ Short term or ☒ Long term

Monitoring activity 1 for improvement: Develop dementia coordinated care planning workflow in HIE.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No internal HIE workflow for dementia care coordination and planning	By July 2020, develop HIE workflow and policy for coordination pathway to share with providers and MA partners	7/31/2020	100% of providers and MA partners trained in use of coordination pathway	10/31/2021

Monitoring activity 2 for improvement: Track use of care coordination pathway by providers

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No coordinated dementia care planning in use	Document percent of members with dementia who have documented dementia care coordination in HIE	12/31/2020	100% of members with dementia have documented dementia care coordination in HIE	12/31/2022
ICP plans for members with dementia are not shared via HIE.	Establish baseline and increase by 30% the members with dementia who have ICP plans shared via HIE	12/31/2021	60% the members with dementia who have ICP plans shared via HIE	12/31/2022
MA plan does not document members receiving medication management monitoring in line with coordinated dementia care planning	Partner with MA plan to develop HIE document plan for members with dementia receiving medication management monitoring	12/31/2021	60% of members have medication management documentation in HIE; MA plan is able to stratify such data by CCO & MA duals	12/31/2022

Members with dementia are not routinely referred for diagnostic testing based on coordinated dementia care planning	Use HIE to establish referral baseline and increase referrals to diagnostic testing for dementia by 25%	12/31/2021	Use HIE to track 100% of referrals. Referrals are documented in HIE as closed loop referral (referral to completed diagnostic testing).	7/30/2022

Activity 2 description: Reduce unnecessary hospital or long-term care readmissions for members with dementia through coordinated care pathway with local dementia specialists, primary care, APD case managers, the CCO and our partner MA plan.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Long term care (LTC) 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