Guidance Document for Transformation and Quality Strategy

The Oregon Health Authority recognizes that the projects included in the CCO Transformation and Quality Strategy submissions are a showcase of current CCO work addressing TQS components that aim to make significant movement in health system transformation. Additionally, OHA recognizes that the work highlighted in the TQS is not a comprehensive catalogue or full representation of the CCO's body of work addressing each component. CCOs are understood to be continuing other work that ensures the CCO is meeting all OARs, CFRs and CCO contract requirements.

Contents

PURPOSE

This document provides instructions and definitions to coordinated care organizations (CCOs) for completing the Oregon Health Authority (OHA) Transformation and Quality Strategy (TQS) template. Per CCO contract, CCOs will continue to move health transformation forward to meet the triple aim of better health, better care and lower costs. The TQS was developed to support (1) sharing of CCOs' best practices; (2) health transformation through innovation and quality methods; and (3) state monitoring of CCOs' progress. Where applicable, integrating the work of health transformation with the federally required quality elements will allow CCOs to adopt synergistic activities. This synergy will help reduce duplicative activities, align CCO priorities, and enhance innovation supported by targeted activities.

OHA will compare each CCO's TQS to their prior year's submission and OHA's written assessment of it to assess continued improvement. OHA expects to see positive changes over time. CCOs are expected to carry over projects from the prior year (unless they meet criteria provided for discontinuing) and are expected to update the project context section with background, rationale and activities accordingly.

TIMELINE

CCOs will submit an annual TQS. OHA will provide feedback to each CCO on their submission. CCOs are meant to use the OHA feedback to improve projects and documentation for the following year. Submit your CCO's TQS and any redaction requests (redacted version and log) to CCO.MCODeliverableReports@state.or.us. Please combine all pieces of your submission into one PDF.

Deliverable	Due Date
2021 TQS	March 15, 2021
Redacted TQS and log (optional)	20 business days after your CCO submits your TQS

RESOURCES AND CONTACT INFORMATION

All TQS guidance documents and resources are updated annually by October 1 and are available at www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx.

OHA and CCOs each have TQS leads, who are the primary points of contact. Questions and communications regarding TQS can be directed to the OHA TQS leads (Transformation.Center@dhsoha.state.or.us).

INSTRUCTIONS

Section 1: Transformation and Quality Project Details

Your CCO must address all 15 TQS components listed here (see component-specific requirements below) with a component prior year assessment, project context, project description, monitoring activities, targets and benchmarks.

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)
7	Health Equity: Data	15	Utilization Review
8	Health Equity: Cultural Responsiveness		

Repeat the TQS project details (Section 1, Parts A-F) until all components have been addressed. CCOs can address up to three components per project, where applicable. Insert additional Parts A-F as necessary.

Continuing projects: Your CCO is expected to carry over projects from the prior year to demonstrate continued improvement efforts. It is essential for CCOs to show progress year over year to meet the transformation goals set across TQS components and move the health system forward in the coordinated care model. Continuation projects will be reviewed with an eye for performance over a period of time.

Questions to consider:

- Are you moving the work to meet member and community needs?
- Does the continued project show progress from the previous year?
- Do the project activities move your CCO toward transformation in the component areas the project addresses?

Discontinuing projects: It's important to recognize when a project will not be able to make progress toward its intended goals. Innovation may result in "quick wins" and early adoption, or "fail fast" and the need to change course. By reporting these lessons, CCOs will allow partners and the community to move on, while showing accountability for the project.

To discontinue a project, it must meet one of these four criteria:

1. Project has failed to meet its expected outcomes and cannot be adapted to meet the outcomes.
2. CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work.
3. Fully matured project that has met its intended outcomes.
4. Project fails to meet TQS guidance in requirements, which ensure health transformation and quality for Medicaid members, for the chosen component(s) based on OHA feedback and/or written assessment.

All discontinued projects must be reported and closed out in Section 2 of the TQS template. This includes identifying the criteria and reason(s) for each discontinued project, along with lessons learned. The CCO TQS lead should contact the OHA TQS leads with any questions.

How to Complete the TQS Template

The level of detail needed will vary for each specific project your CCO submits, depending on the component(s) it addresses, the type of project it is, its stage of implementation, etc.

A. Project Number and Short Title

- ✓ Write a short title, according to the naming convention below, to help identify this project within the larger TQS submission. Titles should follow the convention "Project #: Short descriptor". For example,

"Project 2: Dental care in schools". The project number should be sequential across projects. Do not include the component name in the title.

- ✓ Select whether the project is new or continuing.
- ✓ If project is continuing from the prior year, include the unique project ID provided by OHA.

B. Components

- ✓ Choose up to three components from the dropdown menus that this project addresses. All 15 components must be addressed at some point in the TQS.
- ✓ If this project includes aspects of health information technology, select the appropriate check box.
- ✓ If Social Determinants of Health & Equity (SDOH-E) is selected as a component, identify which SDOH-E domain(s) are addressed. These include economic stability, neighborhood and built environment, social and community health, and education.
- ✓ If CLAS Standards is selected as a component, choose the primary CLAS standard being addressed by selecting from the dropdown.

C. Component Prior Year Assessment

- ✓ **Provide an assessment of the prior calendar year for the component(s) assigned to the project.** Information should include: an overview and brief evaluation of your CCO's work in the component(s) over the last year and existing gaps. This may include narrative, tables and charts (for example, gap analysis, driver diagrams, fishbones, prioritization matrices).
- ✓ **Include CCO-specific or region-specific data that addresses the component.** If CCO-specific data isn't available, CCOs are expected to work with other agencies and community organizations to access region-specific data**.** If no CCO-specific or regional data is available, then explain why.

D. Project Context

- ✓ **If this is a new project, describe why your CCO has chosen this project as a new opportunity**. Include a clear rationale or justification for selecting this project. While this project may not address all gaps from the component's prior year component assessment, the project should be a starting point in moving the component area's health transformation forward and/or serve as a building block to your CCO's organizational and quality efforts for the component area. Details to include: how this project addresses unique characteristics, identified needs and gaps in services of your community, members or network providers.
- ✓ **Include CCO-specific or region-specific data that addresses the project**. If CCO-specific data isn't available, CCOs are expected to work with other agencies and community organizations to access region-specific data**.** If only national or county-level data is available, describe why and what is being done to get CCO-level data. Provide enough detail to demonstrate that the project is a data-informed intervention, and it will achieve the stated goals and produce the desired outcome.
- ✓ **If this project is continued from the prior year, describe progress to date**, including trend data and whether last year's targets and benchmarks were met (and if not, why not), including lessons learned. If revisions have been made to the ongoing project or there is a change in focus, explain the specific changes and why they were made.

E. Brief Narrative Description

- ✓ Write a brief, high-level description of the project intervention(s) to be implemented (or in progress) and the target population. Include enough detail to demonstrate how the project addresses all TQS components selected for the project. Refer to component-specific guidance for each project component to ensure adequate project descriptions. Do not repeat project rationale in this section. Rationale is reported in Section 1 Part D.

F. Activities and Monitoring for Performance Improvement

This section illustrates the activities a CCO plans to implement in the reporting TQS year to move health transformation work forward. It is intended to be the CCO's project workplan. For continued projects, you must update the activities and targets/benchmarks accordingly. If they haven't changed since the prior year, explain why.

- ✓ **Activity descriptions**: These are the tasks, actions, activities and interventions your CCO will undertake during the project to achieve the chosen target or benchmark. Activities should directly relate to the TQS components selected. These could be transformational change activities to the larger system, or smaller and more foundational change activities internal to the CCO (process or quality improvement changes).
  - List one activity at a time, with associated monitoring method(s), and insert additional activity descriptions as needed to capture all activities.
  - Include enough detail to explain how the activity progresses the CCO in addressing the TQS component(s) selected and gaps identified.
  - Every activity must include whether it is short term or long term, how it will be monitored, and the desired outcome (benchmark and target). If long-term activities for a continuing TQS project have not yet been achieved, you can include the same activities in the current TQS submission, but more recent data should be reflected in the project context section. If short-term activities are repeated from the prior year, explain in the project context section why progress wasn't made.
  - Activities listed need to demonstrate significant and meaningful CCO actions throughout the calendar year period to move the project forward.
  - Include an adequate number of activities to move the project forward in a reasonable time. However, OHA recognizes the number of activities listed will vary across projects due to complexity and type of project.
- ✓ **Short-term or long-term activity**: Check which box applies (short term is one year or less; long term is longer than one year). If the activity will not be completed by the next annual TQS submission, it should be designated as long term. For example, a long-term activity might be to support 75% of a CCO's networked primary care providers achieve patient-centered primary care home tier 4 over the next two years.
- ✓ **Monitoring activity for improvement**: 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. There must be a minimum of one monitoring activity for each listed activity. For process measures, the monitoring may be a task (for example, a contract will be issued, stakeholders will be convened and

recommendations made, a baseline will be measured). List additional monitoring activities by inserting additional monitoring descriptions as needed to capture measures of success.

- ✓ **Baseline or current state**: Initial data measurement (may be collected by CCO during investigation of scope of the "problem") and starting point from which the CCO will calculate the project's impact. This box should contain quantitative data (for example, numbers, rates, percentages), unless it is a process measure (for example, a contract is not yet in place, stakeholder group has not been formed, a baseline has not been established). If baselining is one of the early tasks in the performance improvement portion of this table, then the baseline can be noted as "to be determined" until the baseline has been identified. The TQS does not need to be resubmitted once the baseline has been identified, but the baseline must be included in the next TQS submission. If your CCO is continuing a project from a prior year's TQS, include the current state data point instead of the initial baseline from the prior year. If that isn't available, explain why.
- ✓ **Target/future state**: The target is the incremental step toward achieving the benchmark and should reflect what the CCO plans to accomplish or complete in the short term. If this activity is a short-term activity, the benchmark and the target may be the same. The target may need to be determined after the submission of the TQS if baselining has not been completed and is one of the early tasks. The TQS does not need to be resubmitted once the target has been identified, but the target should be included in the next TQS submission. Define your target/future state consistent with SMART (specific, measurable, achievable, relevant, time-bound) objectives. More information about SMART goals is available through the Minnesota Department of Health: https://www.health.state.mn.us/communities/practice/resources/phqitoolbox/objectives.html
- ✓ **Target met by date**: Note the date by which the target will be met in MM/YYYY format. For example, if the target will be met by December 2021, write 12/2021.
- ✓ **Benchmark/future state**: This is the standard or point of reference against which performance may be compared or assessed. CCOs may select national, state or industry best practice standards, or benchmark against their own performance if they have already met national, state or industry standards. The benchmark may need to be determined after the submission of the TQS if baselining still needs to be completed and is one of the early tasks in the project. The TQS does not need to be resubmitted once the benchmark has been identified, but the benchmark should be included in the next TQS submission. Define your benchmark/future state consistent with SMART (specific, measurable, achievable, relevant, time-bound) objectives. More information about SMART goals is available through the Minnesota Department of Health: www.health.state.mn.us/communities/practice/resources/phqitoolbox/objectives.html
- ✓ **Benchmark met by date**: Note the date by which the benchmark will be met in MM/YYYY format. For example, if the benchmark will be met by December 2022, write 12/2022.

Section 2: Discontinued Project(s) Closeout

Insert additional Parts A–D as necessary to complete Section 2 for each project from your CCO's prior year TQS that you're not continuing in this year's TQS.

A. **Project short title**
   - ✓ Insert the short title that was used when the project was originally submitted in your TQS. This is also available in the project name and unique ID numbers list provided by OHA.

B. **Project unique ID**: Insert the unique project identification number from the list provided by OHA. New projects will not have a unique project identification number.

C. **Criteria for project discontinuation**: Select one of the four available discontinuation criteria from the drop-down list. If more than one criterion applies, please write secondary criteria in the following Part D.

D. **Reason(s) for project discontinuation** in support of the selected criteria above; description may include, but is not limited to:
   - ✓ Outcomes data
   - ✓ Rationale for reprioritization of CCO resources toward other topics/project selection
   - ✓ Sustainability plan if goals were met
   - ✓ OHA written feedback or guidance detailing how project did not meet TQS requirements
   - ✓ Lessons learned

Section 3: Required Quality Program Attachments

A. **Attach your CCO's documentation (for example, quality improvement strategic plan, policies and procedures) to describe and demonstrate how your CCO's Quality Improvement Committee addresses the following**:
   1) Overseeing and approving the CCO's annual TQS prior to submission to OHA;
   2) Monitoring related quality assurance performance improvement efforts, transformation strategies and activities (in the context of CCO and subdelegate oversight);
   3) Conducting a quarterly review and analysis of all complaints and appeals received, including a focused review of any persistent and significant member complaints and appeals and ensuring compliance in the context of the grievance system report and grievance and appeals log with quality improvement standards as follows:
      a. Review of completeness, accuracy and timeliness of documentation;
      b. Compliance with written procedures for receipt, disposition and documentation; and
      c. Compliance with applicable OHP rules;
   4) Monitoring findings regarding CCO's compliance with member rights and responsibilities policies and procedures and any subsequent corrective action;
   5) Addressing issues identified through the Quality Improvement Committee review process and ensuring review of results, progress and effectiveness of recommended corrective actions; and
   6) Reviewing written procedures, protocols and criteria for member care no less than every two years, or more frequently as needed to maintain currency with clinical guidelines and administrative principles.

References:

- §438.330 Quality assessment and performance improvement program
- 410-141-3525 – Outcome and Quality Measures (11)
- 410-141-3590 – MCE Member Relations: Member Rights and Responsibilities (1)
- 410-141-3705 – Criteria for CCOs (26)(c)
- 410-141-3915 – Grievances and Appeals: System Recordkeeping (5)
- Exhibit B – Statement of Work: Part 10 Transformation Reporting, Performance Measures and External Quality Review, Sec 2 and 7

B. **Optional**: **Supplemental documentation**

- ✓ Attach any relevant supplemental documents to the TQS. Supplemental documentation is not intended as a replacement for analysis or a comprehensive response within the TQS. Examples of attachments that augment a CCO response include: policies and procedures, component area or project-focused driver diagrams, root-cause analysis diagrams, data to support project problem statements, organizational charts, etc.
- ✓ All supplemental documents *must* reference which project the document is supplementing. This must be noted in both the document's electronic file title *and* the document's content.

C. **Optional**: **CCO characteristics**

- ✓ Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS.

COMPONENT-SPECIFIC REQUIREMENTS

TQS Components: Below is a description of each TQS component. All components must be addressed in the TQS. Applicable OARs, CFRs and contract references are listed for CCOs to obtain further details on component meanings. Project examples listed are to provide CCOs with ideas of projects to develop; examples are not an exclusive or exhaustive list.

1. Access: Cultural Considerations

This component refers to assessment and analysis of the quality and effectiveness of the program operated by your CCO for monitoring, evaluating and improving the access, quality and appropriateness of services provided to members consistent with their cultural and linguistic needs.

Your CCO shall address access to services delivered under the contract with OHA for members with cultural considerations that may impact provision of, or access to, those services. Your CCO shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. Projects must include data and methods used by your CCO for monitoring.

TQS projects for this component must:

- Demonstrate how it promotes access and delivery of services in a culturally competent manner to members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

- Demonstrate how the cultural and linguistic needs of its target population are identified; and
- Outline member participation in the member's plan of care in the delivery of services in the most appropriate setting and in a manner that meets the member's unique needs.

The following are relevant references for this component:

- Your CCO shall provide culturally and linguistically appropriate services and supports in locations as geographically close as possible to where members reside or seek services. Your CCO shall offer a choice of providers (including, but not limited to, physical health, behavioral health (which includes mental health and substance use disorders), oral health, etc.) within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations consistent with CCO Contract Ex B, Pt 4, Sec 2.
- Your CCO shall provide oversight, care coordination, transition planning and management of the behavioral health needs of members to ensure culturally and linguistically appropriate behavioral health care is provided in a way that members are served in the most natural and integrated environment possible and that minimizes the use of institutional care consistent with CCO Contract Ex M, Sec 3e.
- Your CCO shall develop and provide written informational materials and educational programs as described in OAR 410-141-3580 and OAR 410-141-3585. Your CCO shall furnish materials and programs in a manner and format that may be easily understood and tailored to the backgrounds and special needs of the member, or potential member, which comply with the federal requirements in 42 CFR 438.10 and consistent with CCO Contract Ex B, Pt 3.

Project examples:

- Implement policy and procedure with oral health subcontractor to collect, stratify and analyze members' access to standard appointments by ethnicity and language.
- Implement policy and procedure with behavioral health subcontractor to collect, stratify and analyze members' access to standard appointments by ethnicity and language.
- Assess provider clinics and qualified health interpreter accessibility to ensure network provides access for members with language needs.
- Increase use of telemedicine by members whose first language is not English.
- Implement quality improvement project to address disparities in hospital readmission rates in X county for members who identify a primary language other than English.
- Improve rates of disease screening (prevention) among Hispanic (culture) and Spanish-speaking (language) members through use of at-home testing kits.
- Implement process, procedure and policy to stratify data on linguistic and cultural characteristics among members assigned for care coordination after discharge from acute hospital stay.
- Implement community training in X language to increase utilization of non-emergent medical transportation.
- Implement X IT solution to generate member notices in alternate languages and develop process to monitor quality and effectiveness of those communications.
- Implement training for your CCO staff on cultural considerations.

Questions to consider in developing projects:

- High probability that your CCO will need to use several different data sources.
- Age, culture and language data available to demonstrate project is targeting necessary CCO members.
- Geography of proposed project vs. geography of target member group.
- CAC guidance, input and recommendations.
- Data already collected by your CCO that can be stratified by ethnicity or language.
- Data available to demonstrate provider access to members with disabilities through use of TTY, American Sign Language interpreters, auxiliary aids and alternative format materials, and accessible equipment and facilities.
- Data already collected at the county, community level, and data available through member surveys (CAHPS) and from other Oregon institutions or organizations.

2. Access: Quality and Adequacy of Services

This component includes assessment and analysis of the quality and effectiveness of the program operated by your CCO for monitoring, evaluating and improving access, quality and appropriateness of services to ensure that all covered services are available and accessible to CCO members, including how transportation is provided.

Your CCO shall make the services it provides consistent with the CCO Contract Ex B, Pt 2 – including, but not limited to, primary care, oral health, specialists, pharmacy, patient-centered primary care home, OB/GYN, hospital, vision, ancillary and behavioral health services (which includes mental health and substance use disorders), etc. – as accessible to members (both adult and pediatric, where applicable) for timeliness, amount, duration and scope as those services are to fee-for-service members within the same service area.

TQS projects for this component must:

- Plan to improve access, quality and appropriateness of services that ensures all covered services are available and accessible to CCO members (right care at the right time and place, using a patient-centered approach);
- Anticipate member enrollment when determining access needs; and
- Address at least one key factor of realized access (availability, accessibility, accommodation, acceptability, affordability). For more guidance on realized access, see this adequacy and access toolkit from the Centers for Medicare and Medicaid Services.

The following are relevant references for this component:

- Your CCO provider network must have sufficient capacity and expertise to provide adequate, timely and medically appropriate access to covered services to members across the age span from infant to older adult, including full benefit dual eligible members. If your CCO is unable to provide those services locally, it must demonstrate to OHA and provide reasonable alternatives for members to access care (OAR 410-141-3515(9)).

- The services and supports provided by your CCO shall be as close as possible to where members reside and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations (OAR 410-141-3515(3)).
- Your CCO shall support members, especially those with behavioral health issues, in the most appropriate and independent setting, including in their own home or independent supported living (OAR 410-141-3515(6)). Your CCO shall provide oversight, care coordination, transition planning and management of the behavioral health needs of members to ensure culturally and linguistically appropriate behavioral health care is provided in a way that members are served in the most natural and integrated environment possible and that minimizes the use of institutional care consistent with CCO Contract Ex M, Sec 3e. Your CCO shall ensure that each member 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.
- Your CCO must ensure that network providers provide physical access, reasonable accommodations and accessible equipment for members with physical or mental disabilities (42 CFR 438.206(c)(3)).
- Your CCO provider network shall include sufficient family planning providers to ensure timely access to covered services and provide female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist (42 CFR 438.206(b)(2)).

Project examples:

- Implement process for utilization management team to present results of access data analysis to your CCO quality committee and integrate committee feedback, as appropriate.
- Implement project to address gap identified in data collection process by CCO or subcontractors.
- Require that data reported by subcontractors is in standardized format, uses standardized measurement and is delivered timely to your CCO.
- Implement process to standardize communication between acute care facilities and your CCO for members discharging from acute care stay at hospital X.
- Increase availability of screening services for X condition to members in X county through the distribution of at-home testing kits.
- Increase availability of pediatric oral health preventive services within 8 weeks by co-locating oral health office in two primary schools and one middle school in X county.
- Increase member utilization of non-emergent medical transportation to decrease rates of missed appointments for standard oral health services.
- Decrease % of members whose discharge to skilled nursing/rehabilitation facility, from post-acute hospital stay, is delayed.
- Implement contract for crisis services in county X and develop CCO process to monitor contractor compliance and quality of services.
- CCO care coordination team reviews list of adult and pediatric members discharged from acute care, weekly. Team to implement standardized checklist to ensure all members have a treatment plan and all follow-up needs identified in the plan are addressed.

- Decrease emergency department utilization by adults for non-emergency behavioral health care by X% in county X.
- CCO care coordination team will develop process and implement program to schedule member outpatient follow-up appointments, prior to member discharge from acute hospital stay.
- Assess member participation in developing or modifying treatment plans.
- Assess disability-competent care practices, training or accessibility at provider offices.

Questions to consider in developing projects:

- How does project support member choice and make services covered by CCO contract more accessible/available to member?
- Availability of standard, urgent and emergency services for all service types (physical, behavioral, oral health).
- Availability of services for all age groups and geographic service area.
- Availability of services for specific CCO member populations: cultural, language, disability, special health care needs, severe and persistent mental illness (least restrictive setting, or reasonable alternative).
- CAC guidance, input and recommendations.
- Provider and member input and recommendations.
- Data already collected by your CCO that can be stratified to ensure access to services is equitable.
- How does the proposed project contribute to members getting the right care, at the right time, and in the right place with appropriate coordination, continuity and use of medical resources and services?
- Utilization data can indicate gaps in access or services; however, it does not usually provide causation. Additional assessment, root cause analysis, and investigation by your CCO will be needed. What additional resources and data may be needed to assess gaps?
- How do the processes developed by your CCO result in patient-centered care and support member choice?
- How will your CCO evaluate members to ensure placement in settings that are appropriate, the most integrated appropriate for that person, and that members' needs are re-evaluated at regular intervals to capture changes?
- What mechanisms or tools does your CCO use to communicate member needs when CCO members transfer between levels of care, following discharge from acute settings or between outpatient care settings?

3. Access: Timely

This component refers to assessment and analysis of the quality and effectiveness of the program operated by your CCO for monitoring, evaluating and improving timely access to services provided to members.

TQS projects for this component must:

- Plan to improve timely access to services.

- Apply OHA travel time and distance standards in OAR 410-141-3515 for timely access to care and services, taking into account the urgency of the need for services (42 CFR 438.206(c)(1)(i)). If OHA standards are not used in the project submitted, explain why and include the criteria used.
- Demonstrate oversight of provider network to monitor and address compliance. Examples include, but are not limited to, establishing mechanisms to ensure compliance by providers, regular monitoring of providers to determine compliance or taking corrective action for provider failure to meet timely access requirements.

The following are relevant references for this component:

- Your CCO shall ensure scheduling and rescheduling of member appointments are appropriate to the reasons for, and urgency of, the visit. The member shall be seen, treated or referred within the timeframes described in OAR 410-141-3515 for routine, urgent and emergency care. Your CCO shall include meta-analysis of aggregate data and indicate methods used to monitor quality and compliance.
- Managed care entities shall ensure 90 percent of members in each service area have routine travel time or distance to PCPCHs or PCPs; primary care, adult and pediatric; OB/GYN; behavioral health (mental health and substance use disorder), adult and pediatric; specialists, adult and pediatric; hospital; pharmacy; oral health, adult and pediatric; and additional provider types when it promotes the objectives of OHA may not exceed the following, unless otherwise approved by OHA:
  - In urban areas: 30 miles, 30 minutes or the community standard, whichever is greater
  - In rural areas: 60 miles, 60 minutes or the community standard, whichever is greater

Project examples:

- Implement a process with your CCO data analytics unit and behavioral health subcontractor to stratify data collected on pediatric member wait times for standard and urgent behavioral health services. Draft and implement policy and procedure for your CCO quality committee to review the stratified data.
- Implement policy and procedure addressing subcontractor reporting of time and distance for specific provider types in OAR 410-141-3515.
- Implement policy and procedure for CCO oversight, including education of subcontractors, quality committee and/or clinical advisory panel review for your CCO subcontractors who are unable to meet OAR standards.
- Expand school oral health program to X schools in county to decrease pediatric member travel time for standard oral health appointment from average of 90 miles to 50 miles.
- Decrease average wait time for standard appointment with specialty dentist (not a primary care dentist) to 12 weeks for member in X county.
- Increase the number of non-emergent medical transportation providers in county X during X times, M-F, to decrease member wait for behavioral health (standard) appointments from average of 6 weeks to average of 4 weeks.
- Survey members and providers to assess acceptability and feasibility of tele-health visits with PCPs.

Questions to consider in developing projects:

- How does the project and measurement selected by your CCO apply OAR and contract standards for time and distance, or time to appointment?
- Should your CCO select a measure of timely access not included in OAR or CCO contract, project assessment must include description of how measure selected aligns with those standards. You should include assessment of why measurement selected by your CCO is better for members than state established timeframes.

4. Behavioral Health Integration

This component refers to your CCO's development and implementation of an equitable, integrated, person-centered behavioral health system that seamlessly and holistically integrates physical, behavioral and oral health. This system should be one that members can count on, regardless of where they live, to meet their needs. The system should support all integration models from communication to coordination to co-management to co-location to the fully integrated patient-centered primary care home and behavioral health home.

TQS projects for this component must:

- Demonstrate clear understanding of definition and models of integration and integrated setting for behavioral health and physical health;
- Cover the continuum of care – prevention, treatment and recovery;
- Demonstrate how the integration model makes the behavioral health system more equitable;
- Utilize the electronic health record/health information exchange system in the infrastructure to support integrated care delivery;
- Implement a care team structure that includes all disciplines involved in the member's behavioral health and primary care; and
- Clearly explain strong collaboration and partnership with other regional health providers such as school-based health centers, substance use disorder providers, community mental health programs and primary care providers, and other community partners such as law enforcement.

The following are relevant resources for this component:

- Behavioral health integration tip sheet: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Behavioral-Health-Integration-Tip-Sheet.pdf
- Behavioral health integration resources from the Patient Centered Primary Care Institute: http://pcpci.org/search/resources/topic/behavioral-health-integration-49

Project examples:

- Allow members to receive behavioral health services in primary care settings and/or primary care services in behavioral health settings.
- Increase the availability of integrated behavioral health services, including increasing the capacity and number of integrated behavioral and physical health providers and clinics.

- Pay for behavioral health services using payment models that promote integration, such as paying for behavioral health and physical health visits that occur on the same day in the same clinic, eliminating double co-pays and contracting with integrated clinics for all services in one contract.
- Develop and implement plans, in collaboration with the behavioral health provider community, to expand the range of behavioral health services that engage individuals in the community with the services and supports they need, when they need them, where they need them, and at the right intensity.
- Increase utilization of comprehensive screenings of mental health, substance use disorder and physical health, using evidence-based screening tools, in physical and behavioral health care settings.
- Provide training and support to increase member access to medication-assisted treatment.
- Develop and implement processes to improve and standardize communication between physical and behavioral health providers.
- Engage members in assessing receipt of and experience with integrated behavioral health. Develop and implement processes and projects to use the feedback to improve care across members.
- Assess and improve access by priority populations to intensive care coordination (ICC) services that are person-centered, trauma informed, and delivered as part of a care-team approach in a care setting that best meets the needs of the member.
- Improve coordination of care within the behavioral health system, in particular focusing on the most vulnerable populations. This is especially crucial to support effective member transition between levels of care, different systems and providers to improve care outcomes, reduce over-utilization, reduce additional trauma to the member due to system issues and realize cost-effective savings in the long term.

Questions to consider in developing projects:

- How is your CCO providing members access to a full range of behavioral health treatment and recovery options in the member's preferred setting of care (such as primary care clinics and behavioral health clinics)?
- How is your CCO assessing timeliness of access to services and how will your CCO address gaps and improve access?
- How is your CCO improving collaboration with community behavioral health providers to expand the range of behavioral health services in the community?
- How is your CCO increasing member access to medication-assisted treatment when medically appropriate?
- How is your CCO assessing and supporting seamless integration of the behavioral health benefit, and how will your CCO address any gaps?
- How are trauma informed services integrated into your system of care? What opportunities are there for improvement?
- What percentage of members are screened for mental health, substance use disorder and physical health care using evidence-based screening tools? What opportunities are there for improvement?

- How is your CCO contracting and paying for behavioral health services that promotes integration? What opportunities are there for improvement?
- How will your CCO monitor and support intensive care coordination?

5. CLAS Standards

This component refers to your CCO's work in implementing activities to support the National Culturally and Linguistically Appropriate Services (CLAS) standards. The National CLAS standards establish a blueprint (CLAS Standards Blueprint) for CCOs and the provider network and provide specific recommendations for addressing inequities at every point where the CCO member has contact with the health care system. Ensuring full CLAS standards are a part of a CCO's foundation and operations are further referenced in the CCO contract and CCO requirements.

Projects for this component will move the CCO's work in meeting the CLAS standards in health care. The CLAS Standards Blueprint defines "culturally and linguistically appropriate services" in CLAS standard 1 as the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Standard 1 is the principal standard because it is the ultimate aim in adopting the remaining standards. Standards 2 through 15 represent the practices and policies intended to be the fundamental building blocks of culturally and linguistically appropriate services that are necessary to achieve standard 1. For this reason, CCOs will choose from standards 2 through 15 for focusing their TQS project(s). For OHA, the incorporation of CLAS standards in every aspect of the CCO and provider network is the primary long-term goal.

TQS projects for this component must:

- Demonstrate the process or actions undertaken to implement at least one of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.
- Fully support transformation and quality in moving health equity forward.
- Identify the primary CLAS standard you are addressing within your TQS project. In the TQS template, select one standard from the drop-down list of standards 2-15. If your project meets multiple CLAS standards, you are welcome to add that information, but OHA's evaluation will focus on the selected primary CLAS standard.
- Provide enough detail to explain how the project, activities and monitoring address the specific CLAS standard selected.

The following are relevant references for this component:

- The 15 National CLAS standards are intended to advance health equity, improve quality and help eliminate health care disparities. The full list of CLAS standards is available at: https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf
- For a robust and comprehensive guide on how to implement CLAS standards, see: https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedCLASStandardsBlueprint.pdf

Project examples:

- Develop a monitoring system for language assistance services to analyze existing services to improve upon how they can become more accessible, effective and efficient.
- Develop required scripts for CCO staff for consistently informing individuals of the availability of language assistance and inquiring whether they will need to utilize any of the available services (short term).
- Develop an evaluation system to assess the quality of translations for member materials. This may include testing materials with target audiences.
- Integrate CLAS into continuous quality improvement processes (for example, organizational assessments, CLAS-oriented surveys for consumers, focus groups with staff and consumers to identify barriers to CLAS implementation, CLAS-related questions in staff orientation materials and yearly reviews).

Questions to consider in developing projects:

- What does current CCO data tell us about the language needs of members?
- What does current state and local data tell us about potential CCO members?
- How do local community listening sessions and community advisory councils inform or shape which CLAS standards your CCO is focusing on?
- How does current demographic data about CCO employees and the current demographic data about CCO membership help evaluate and inform which CLAS standards are chosen?
- What were the highest priorities identified by the CCO, and which National CLAS Standard(s) can help the organization address those needs?
- What broader contexts (for example, regulatory environment, mandates, standards of practice) might influence the CCO goals and objectives, and which National CLAS Standards should the CCO adopt first? Are there opportunities to align those goals and objectives with these broader contexts? Can the community be involved?
- When evaluating projects, to what extent has the implementation of the National CLAS Standards led or contributed to:
- The use of data on race, ethnicity, sex, gender identity, disability status, and language to monitor and improve health service delivery?
- Improved two-way communication between providers and members?
- Increased knowledge of culturally and linguistically appropriate care and buy-in from staff?

6. Grievance and Appeal System

This component refers to assessment and analysis of the quality of the grievance and appeal system (inclusive of complaints, notice of actions, appeals and hearings) operated by your CCO, including aggregate data to indicate your CCO's quality improvement activities. CCOs are responsible for several reporting requirements for the grievance system per the CCO contract. While these required deliverables may not be substituted for this TQS component, they provide opportunity for process improvement and data on your CCO's grievance and appeal system to demonstrate improvement in outcomes.

TQS projects for this component must:

- Provide grievance and appeal data, including a composite analysis using trend, meta data across the prior year
- Plan to improve, including details of the grievance system changes to be instituted based upon the gaps identified in composite analysis
- Identify and describe in the project description whether the project will aim to do one of the following:
    - Improve operational processes within the CCO and/or across the CCO region;
    - Use data to identify where trends are and implement projects to alleviate the barriers to care; or
    - Describe how the project falls outside of the two areas listed above.
- Ultimately focus on implementing improvements to affect outcomes.

These potential grievance and appeal system project areas are further described below, including example projects or activities your CCO can undertake to enhance the quality and compliance of your grievance and appeal system in the following areas:

- Developing and maintaining a grievance and appeal system
- Ensuring the grievance and appeal system is accessible to all members
- Using data from the grievance and appeal system for analysis, identifying trends and taking steps to improve the quality of services
- Monitoring of CCO delegates when the grievance and appeal system has been delegated to subcontractors or providers

Developing and maintaining a grievance and appeal system

Your CCO shall have a member grievance and appeal system, supported with written procedures that include a grievance process, notice of adverse benefit determination process (NOABD), appeal process and access to contested case hearings.

References:

- CCOs' grievance and appeal systems shall meet the requirements of Exhibit I, OAR 410-141-3875 through 410-141-3915, and 42 CFR 438.400 through 438.414, 438.420, and 438.424.

Project examples:

- Develop or improve the quality of the grievance and appeal processes within the CCO.
- Reorganize internal processes that include contracted providers to ensure the requirements of the grievance and appeal system are met.
- Improve coordination and communication with OHA Hearings Unit.
- Improve or streamline record retention.
- Formalize ongoing monitoring processes of both CCO and subcontracted provider grievance and appeal systems in accordance with OAR and CFR for grievance and appeal system.

Ensuring the grievance and appeal system is accessible to all members
The grievance and appeal system operated by CCOs must be accessible to all members including those with a disability or limited English proficiency. Your CCO appeal process must ensure a member can request an appeal within 60 days of receiving a NOABD.

References:

- CCO contract Exhibit I 1(e)(1–7)

Project examples:

- Develop and formalize policies and procedures to identify when member materials need to be updated to ensure members have the latest information about accessibility to the grievance and appeal system.
- Improve your CCO's subcontractor monitoring process to ensure appropriate forms are available, are language appropriate, etc., and services are being provided appropriately.
- Streamline NOABD and appeals process to ensure required timeframes are met.
- Improve the readability of adverse benefit determination notices (short term project).
- Develop and provide training to your CCO staff and contracted provider staff on appropriate handling of all parts of the grievance and appeal system.
- Measure effectiveness through complaint data.
- Implement new software or upgrade software and develop internal processes to ensure all grievance and appeals are tracked and reported as required.
- Process improvements to include training; evaluate your CCO staff and contracted provider staff on new processes and procedures to ensure all steps of the grievance and appeal process are appropriately tracked to improve the quality of reporting.
- Formalize monitoring processes of all contracted providers.

Using data from the grievance and appeal system for analysis, identifying trends and taking steps to improve the quality of services
Your CCO shall address the analysis of grievances and appeals in the context of quality improvement including review of completeness, accuracy and timeliness of documentation, compliance with written procedures for receipt, disposition and documentation, and compliance with applicable OHP rules.

Your CCO is required to use data collected from monitoring of its grievance system to analyze its grievance system. This may include the grievance and appeal data reported to OHA in the grievance and appeal log. The analysis of the grievance system for this TQS component shall demonstrate how your CCO uses data collected by the CCO and its sub-delegates to maintain an effective process for monitoring, evaluation and improving the access, quality and appropriateness of services provided to members. Improvement projects involve your CCO identifying specific areas where the data shows trends or gaps and developing interventions to improve those areas.

Project examples:

- Develop policies and procedures that identity how high numbers of complaints from a provider, clinic, or a specific type of service will be reviewed and determinations made for eliminating barriers to services.
- Develop internal processes to identify steps taken to identify and review where high numbers of notice of adverse benefit determinations are being issued.
- Develop processes to evaluate the number of appeals in a particular area, by specific subsections of members (age, ethnicity, gender, SPMI etc.) or from specific subcontractors, or types of services.

Monitoring of CCO delegates when the grievance and appeal system has been delegated to subcontractors or providers

Your CCO should ensure data collected by subcontractors is included in CCO analysis of grievance system, and the data is reviewed by your CCO compliance committee, consistent with contractual requirements for CCO quality improvement.

References:

- Your CCO must ensure any subcontractors meet the requirements consistent with OAR 410-141-3505 and 410-141-3875(14), monitor the subcontractor's performance on an ongoing basis, perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement, and ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement (CCO Contract Ex I, Sec 1e (10)).

Project examples:

- Develop and formalize policies and procedures for an escalation process for handling subcontractor performance deficiencies identified through monitoring findings.
- Use complaint data to monitor improvement, ensuring your CCO has policies and procedures for monitoring subcontractors and providers.

Health Equity

These components refer to your CCO's application of an equity-centered care management system to identify and address systemic inequities in services, policies, practices and procedures with a focus on eliminating racial, ethnic and linguistic health disparities.

CCOs are encouraged to center their equity work in the health equity definition developed by the Health Equity Committee (HEC) and adopted by the Oregon Health Authority in 2019:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- *The equitable **distribution or redistribution** of **resources** and **power**; and*
- ***Recognizing**, **reconciling** and **rectifying historical** and **contemporary injustices**.*

OHA expects your CCO to move health equity forward through **transformation and quality** projects, as reported in the TQS. CCOs will ensure an adequate health equity infrastructure is part of their foundation and operations as a result of additional requirements in the current CCO contract (see Exhibit K for health equity infrastructure details).

7. Health Equity: Cultural Responsiveness

Culturally responsive services are those that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse consumer/client populations and communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. **Cultural responsiveness describes the capacity to respond to the issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual.**[1]

Your CCO shall ensure that members receive effective, understandable and respectful care from all CCO staff and the provider network. The CCO shall ensure that health and health care services (including physical health, behavioral health, substance use disorder and oral health services) are provided in a manner compatible with members' cultural health beliefs, practices, preferred language and communication needs.

TQS projects are expected to align — but move beyond — contractual obligations to focus on quality improvement and transformation.

TQS projects for this component must:

- Describe whether the project is addressing quality improvement or transformation, and describe why.
- Consider state and federal laws regarding communication and accessibility in its design.
- Describe how it will improve the assistance members receive in navigating the health care delivery system and in accessing community and social support services and statewide resources.

The following are relevant references for this component:

- In accordance with OAR 410-141-3590(2), OAR 410-141-3705(15) and OAR 410-141-3580(6)-(7), CCOs shall ensure that members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources. This includes, but is not limited to, the use of certified or qualified health care interpreters, advocates, community health workers, peer wellness specialists and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need

[1] 3 p. 12, Department of Health (2009). Cultural Responsiveness Framework: Guidelines for Victorian Health Services. Rural and Regional Health and Aged Care Services, Victorian Government, Melbourne. Victoria

to access appropriate services and to participate in processes affecting the member's care and services.

- CCOs shall have written policies and procedures that ensure compliance with the Americans with Disabilities Act as amended in 2008 and Section 1557 of the Affordable Care Act (45 CFR Part 92) in providing access to covered services for all members and shall arrange for services to be provided by non-participating referral providers when necessary (OAR 410-141-3515(12)(e)).
- CCOs shall ensure members and potential members are aware of their rights to free, accurate and timely oral and sign language interpretation services in any language by a certified or qualified health care interpreter as described in OAR 410-141-3580, OAR 410-141-3585 and 45 CFR 92.201.
- Your CCO shall develop and provide written informational materials and educational programs as described in OAR 410-141-3580 and OAR 410-141-3585. Your CCO shall furnish materials and programs in a manner and format that may be easily understood and tailored to the backgrounds and special needs of the member, or potential member, and that comply with the federal requirements in 42 CFR 438.10.
- In compliance with the Americans with Disabilities Act, any written material that is generated and provided by your CCO under the CCO contract to clients or members, including Medicaid-eligible individuals, shall, at the request of such clients or members, be reproduced in alternate formats of communication, including Braille, large print, audiotape, oral presentation, and electronic format (CCO Contract Ex D, Sec 2b).

Many opportunities exist for CCOs to demonstrate cultural responsiveness within processes established by the CCO and subcontractors **using quality improvement and transformation activities**.

Project examples:

- Assess current health care workforce to the communities served to address cultural considerations; subsequent expansion of community health workers into service area based upon assessment.
- Develop improvement strategies for monitoring systems that track the use of interpreter services (in person and video/phone) to ensure members are aware of their rights to interpretive services.
- Develop improvement strategies to ensure quality interpretive services are available to members (for example, developing in house training programs supporting certification of interpreter network or monitoring access of interpreters).
- Develop process improvement strategies to ensure subcontractors such as non-emergent medical transportation (NEMT) can field calls in other languages and can accommodate callers with disabilities.
- Improve CCO process for the development and translation of written materials to ensure documents are available in a timely manner in multiple languages and formats (short term).
- Develop systems and processes to ensure behavioral and oral health services are culturally and linguistically appropriate.
- Review existing case management programs to ensure information on intensive care coordination services is offered in a culturally and linguistically appropriate manner (short term).

Questions to consider in developing projects:

- Does the project address a quality improvement or transformation work for advancing health equity?
- Does the project align with the OHA health equity definition and if applicable explain why no alignment to OHA health equity definition?
- Does the project clearly explain how the activities support the OHA health equity definition?
- Has your CCO used an equity lens or a health equity impact assessment to inform this project? (If so, please provide a copy of the tool or include enough detail to illustrate a health equity lens has been applied.)

8. Health Equity: Data

Your CCO shall adopt processes that allow stratification of quality data by patient race, ethnicity and language in every area of the organization as a tool for providing culturally and linguistically appropriate services to advance health equity and for uncovering and responding to health care disparities. Unless specifically measured, racial and ethnic disparities in health care and/or any unintended consequences can go unnoticed by health care organizations, even as these organizations seek to improve services.

TQS projects for this component must:

- Describe whether the project is addressing quality improvement or transformation, and describe why.
- Clearly demonstrate **how you will use data** to support efforts to eliminate health disparities and provide culturally and linguistically responsive services.
- Demonstrate an operational understanding and use of demographic data collection.
- Demonstrate the CCO has adopted or plans to adopt processes that allow the stratification of quality data by race, ethnicity, language and disability.

The following are relevant references for this component:

- The National Healthcare Quality and Disparities Report annual reports and chartbooks are available here: www.ahrq.gov/research/findings/nhqrdr/index.html.

Questions to consider in developing projects:

- Does the project address quality improvement or transformation work for advancing health equity?
- Does the project align with the OHA health equity definition, and if not, explain why it doesn't align to OHA's health equity definition?
- Does the project clearly explain how the activities support the OHA health equity definition?
- Describe any tools used (for example, if your CCO plans to use an equity lens or a health equity impact assessment for the project, provide a copy of the tool or include enough detail).

Project examples:

- Review existing CCO data systems for collecting REALD data to determine baselines (short-term project) or determine areas where systems can be improved.
- Use data to develop an ongoing assessment of staff demographics and promotion demographics.

- Use health equity data in the development of VBP process and to monitor for unintended consequences.
- Develop integrated data system to assess community health from a health equity perspective.

9. Oral Health Integration

This component refers to your CCO's development and implementation of an equitable health care delivery model that seamlessly and holistically integrates physical, behavioral and oral health.

TQS projects for this component must:

a. Allow members to receive targeted non-oral health care, such as diabetes, hypertension, and tobacco screenings, and referrals from a dental provider **OR** basic oral health screenings and referrals in their primary care provider's office; **and**
b. Allow members to access oral health care outside of the traditional dental office; **and**
c. Enable dental providers to share member health information with primary care and behavioral health professionals through health information technology.

The following are relevant references for this component:

- Qualis Health Oral Health Integration Resources: https://www.qualishealth.org/our-services/practice-transformation/oral-health-integration
- Implementation Guide: Organized, Evidence-Based Care: Oral Health Integration: http://www.safetynetmedicalhome.org/sites/default/files/Guide-Oral-Health-Integration.pdf
- Integration of Oral health and Primary Care Practice: https://www.hrsa.gov/sites/default/files/hrsa/oralhealth/integrationoforalhealth.pdf
- Gambhir RS. Primary care in dentistry: an untapped potential. J Family Med Prim Care. 2015 Jan-Mar; 4(1): 13–18. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4366984/

Project examples:

- Care coordination targeting tobacco users, pregnant members and members with diabetes and hypertension for oral health interventions that improve overall health outcomes.
- Electronic oral health records to support work and connect to other health records within the CCO systems.
- Expanded delivery modalities, such as co-location, teledentistry, and cross-training of medical professionals.

Patient-Centered Primary Care Home

Your CCO shall support the continued adoption and advancement of the Oregon Patient-Centered Primary Care Home (PCPCH) model within clinics. Your CCO shall develop and use PCPCH and other patient-centered primary care approaches to achieve the goals of health system transformation (CCO Contract Ex B, Pt 4, Sec 6a).

PCPCH means a health care team or clinic as defined in ORS 414.655 that meets the standards pursuant to OAR 409-055-0040 and has been recognized through the process pursuant to OAR 409-055-0040.

10. PCPCH: Member Enrollment

Your CCO shall provide assurances that a significant percentage of members are enrolled in PCPCHs recognized as Tier 1 or higher according to Oregon's PCPCH recognition standards.

TQS projects for this component must:

- Have a comprehensive plan for increasing member assignment to PCPCHs. The plan should include activities for increasing the number of enrollees served by recognized PCPCHs, including targets and benchmarks.

The following are relevant references for this component:

- Oregon Patient Centered Primary Care Home Program website: https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx
- Your CCO shall encourage the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as PCPCHs to ensure the continued critical role of those providers in meeting the health of underserved populations (CCO Contract Ex B, Pt 4, Sec 6f).

Project examples:

- Strategy to increase members assigned to recognized PCPCHs
- Strategy to increase the number of PCPCHs in your CCO's network to include identifying and contracting with PCPCHs in your service area that are not in your network
- Individual technical assistance to primary care clinics in your network interested in PCPCH recognition (non-PCPCHs) on applying for PCPCH recognition

11. PCPCH: Tier Advancement

TQS projects for this component must have a comprehensive plan to support PCPCH sites in upward tier recognition. The plan must include targets and benchmarks that support PCPCHs to advance from Tier 1 toward Tier 5 (5 STAR) in Oregon's PCPCH recognition standards.

Project examples:

- Learning collaboratives (in-person or virtual) for PCPCHs on implementing advanced PCPCH model measures
- Individual technical assistance to PCPCHs or primary care clinics interested in PCPCH recognition (practice coaching)
- Value-based payment arrangements with PCPCHs that encourage and support higher tier level attainment

12. Serious and Persistent Mental Illness (SPMI)

In this component, your CCO shall demonstrate improvement in an area of poor performance in care coordination for members with SPMI. While it's important to identify the parameters and requirements in rule and contract, the goal of SPMI TQS projects should be to bolster the care coordination between payer, provider and patient to impact patient outcomes.

TQS projects for this component must:

- Plan to improve an area of poor performance in care coordination for members with SPMI, which reflects a thorough understanding of the effects of SPMI on individual functioning, access to care, and utilization of services;
- Support self-determination and be person centered;
- Demonstrate clear commitment to providing services in the most integrated setting;
- Include a report of aggregate data indicating the number of members identified and methods used;
- Be informed by social determinants of health; and
- Focus on improving patient outcomes.

The following are relevant references for this component:

- The Oregon Performance Plan (OPP) is designed to improve mental health services for adults with SPMI through performance outcomes measures, quality and performance improvement measures and gathering, studying and reporting data. Information and resources related to the OPP are available online: https://www.oregon.gov/oha/HSD/BHP/Pages/Oregon-Performance-Plan.aspx
- Your CCO shall have a process for coordinating care for members determined through assessment to need a course of treatment or regular care monitoring (OAR 410-141-3860 and OAR 410-141-3870). The procedure shall include drafting a treatment plan and formally designating a person or entity as primarily responsible for coordinating the services accessed by the member (42 CFR 438.208).
- Your CCO shall provide intensive care coordination or case management services to members with SPMI receiving home and community-based services under the State's 1915(i) State Plan Amendment (CCO Contract Ex B, Pt 4, Sec 8h).
- Your CCO shall ensure access to supported employment services for all adult members with SPMI seeking these services, in accordance with OAR 309-019-0275 through 309-019-0295. "Supported employment services" means the same as "individual placement and support (IPS) supported employment services" as defined in OAR 309-019-0225 (CCO Contract Ex M).
- Your CCO shall have policies and procedures for assessing and producing a treatment plan (individual service and support plan) for each member identified as having special health care need and determined to need a course of treatment or regular care monitoring (CCO Contract Ex B, Pt 4, Sec 2f and Ex B, Pt 4, Sec 2a (6)).
- Your CCO shall have policies and procedures for producing an individual management plan for individuals with SPMI who have two or more readmissions to either an emergency department or acute care psychiatric facility within a 6-month period.

13. Social Determinants of Health & Equity

This component refers to your CCO's development and implementation of initiatives to address the community-level social, economic and environmental conditions that impact health, or the social determinants of health (SDOH). SDOH are shaped by structural and systemic factors, such as the distribution of money, power and resources; institutional bias; and racism. These factors are called the social determinants of equity (SDOE),[2] and lead to disparities in how SDOH impact communities.[3] Social determinants of health and equity (SDOH-E) can contribute to members' social needs – such as a need for stable housing or healthy food in order to be healthy.

TQS projects for this component must:

1. Actively engage members to participate in the development of holistic approaches to patient engagement and responsibility that account for social determinants of health and health disparities (CCO Contract Ex B, Pt 3, Sec 1b).
   - A CCO can meet the requirement for member engagement in a number of ways. Examples include describing the role of the CAC in approving or providing consultation on the SDOH-E project; describing how member perspectives were prioritized in selecting the project; or, if the project aligns with CHP priorities or strategies, describing how members were engaged in selecting CHP priorities and strategies.
   - To meet the requirement, your CCO must explicitly describe member engagement in the TQS submission.
2. Address social needs *at a community level*, beyond working with individual members, through collaboration between the health care system and community partners. This may include programs, such as screening and referral programs, that will ultimately allow the CCO to address individual social needs.
   - To meet the requirement, your CCO should list the community partners involved in the project and describe the collaboration between organizations. Examples of community partners are those listed in OAR 410-141-3730.
   - Strong submissions will demonstrate that the CCO is implementing SDOH-E projects outside the clinic setting and leveraging the expertise of SDOH-E partners and other culturally specific organizations that serve systemically underserved and vulnerable communities.
3. Show how community needs and priorities were considered in development the project.
4. Address one or more of the four key SDOH-E domains (see examples on the next page):
   a) Economic stability
   b) Neighborhood and built environment
   c) Education
   d) Social and community health

Medical interventions, including those for oral and behavioral health, do not meet TQS project requirements.

[2] See OAR 410-141-3735 for definitions of SDOH-E.

[3] Jones, C. et al. 2009. Addressing the social determinants of health: a cliff analogy. *Journal of Health Care for the Poor and Underserved. 20*(4): 1-12.

Project examples by SDOH-E domain:

SDOH Domain	Examples	Project examples
Economic Stability	• Income/poverty • Employment • Food security/insecurity • Diaper security/insecurity • Access to quality childcare • Housing stability/instability (including homelessness) • Access to banking/credit	• Provide financial or non-financial supports to local organizations working to enact anti-poverty policies • Advocate for land use policies to allow for "tiny homes" to increase affordable housing in the community
Neighborhood and Built Environment	• Access to healthy foods • Access to transportation (non-medical) • Quality, availability and affordability of housing • Crime and violence (including intimate partner violence) • Environmental conditions • Access to outdoors, parks	• Partner to support community enhancements, such as park improvements and bike lanes
Education	• Early childhood education and development • Language and literacy • High school graduation • Enrollment in higher education	• Partner with school districts to implement the Good Behavior Game in local elementary schools • Partner to support high school completion programs, such as mentoring programs
Social and Community Health	• Social integration • Civic participation/community engagement • Meaningful social role • Discrimination (for example, race, ethnicity, culture, gender, sexual orientation, disability) • Citizenship/immigration status • Corrections • Trauma (for example, adverse childhood experiences [ACEs])	• Partner across sectors to increase trauma-informed and ACEs trainings in key community settings, such as schools, agencies and businesses • Increase support for community health workers (CHWs), including programs in which CHWs are stationed in key environments, such as housing communities. In this example, CCOs would need to describe how supporting the use of CHWs improves social determinants of health for systemically underserved and vulnerable communities.
All domains		• Establish a medical legal partnership to support members with legal concerns related to housing, discrimination, immigration and other areas

	• Implement social determinants of health screening and referral in your community

Questions to consider in developing projects:

- How is the project is aligned with community priorities, such as those in a shared community health improvement plan with local public health authorities and hospitals, or an analysis of community plans to identify aligned priorities?
- How has your CCO engaged its community advisory council in directing, tracking, and/or reviewing the work?
- How is your CCO is collaborating with community partners, such as community-based organizations?

14. Special Health Care Needs (SHCN)

This component refers to your CCO's assessment and analysis of the quality and appropriateness of care furnished to members with special health care needs used to:

- Ensure that 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;
- 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;
- 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
- 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.

"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 (for example, serious chronic illnesses or certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care and potential increased need for behavioral health care). As outlined in OAR 410-141-3860, members receiving Medicaid funded long-term care or long-term services and supports should be assessed and considered as a population that often may have risks and health conditions that place them into SHCN populations. You may consider aligning your project with CCO metrics goals, such as targeting increasing behavioral health screenings for members in long-term care settings.

TQS projects for this component must:

- Ensure SHCN members, as defined above, have access to appropriate care and care coordination, development of treatment plan or addressing 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 definition above;
- 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 requirements.

For CCOs with Dual Special Needs Plan (DSNP) contracts

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 DSNP. 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. 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.

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

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

If your CCO doesn't have a DSNP contract, your CCO is still strongly encouraged to develop a special health care needs project for FBDE members in partnership with affiliated/contracted MA plans or DSNP.

The following are relevant references for this component:

- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs (42 CFR 438.330(b)(4)).
- Coordination and continuity of care for dually eligible enrollees. Methods with a report of aggregate data indicating the number of members identified and methods as outlined in 42 CFR 438.208(c).
- CCO contractual obligations for SHCN members are described in your CCO Contract Ex B, Pt 4, Sec 2f (Providers and Delivery System: Access to Care) and Ex B, Pt 4, Sec 5b (Delivery System Dependencies: Intensive Care Coordination for Special Health Members).
- Your CCO shall have policies and procedures for assessing and producing a treatment plan (individual service and support plan) for each member identified as having special health care need and determined to need a course of treatment or regular care monitoring (CCO Contract Ex B, Pt 4, Sec 2f and Ex B, Pt 4, Sec 5b (4)).

- Your CCO shall develop evidence-based or innovative strategies for use within their delivery system networks to ensure access to integrated and coordinated care, especially for members with intensive care coordination needs (OAR 410-141-3860, OAR 410-141-3865 and OAR 410-141-3870).

Questions to consider in developing projects:

- How might working with any of your affiliated MA plans, including DSNPs, on a project around FBDE also address required CCO contract elements relating to care coordination, care transitions and care planning for your FBDE populations in the CCO contract?
- What short-term and long-term measurable monitoring activities might be incorporated?
- What data might already be collected for required tracking and CCO 2.0 requirements around SHCN populations and subpopulations and what links could be built-in to the project?
- How the project aligns with specific HIE, behavioral health, DHS partner collaboration, or other core projects already in place?
- How might tracking referrals to and from LTSS be incorporated as a monitoring tool?
- Is your CCO using event notifications (HEN and SNF) and HIE to develop care guidelines, push out care notifications and build collaborative care plans with providers (how can this improve goals, outcomes and tracking)?
- How do you use data to ensure members are receiving screenings and preventive care, including behavioral health screenings, in your monitoring?
- How do you use monitoring of care or service authorization data to track who may be underutilizing prevention and care management to improve outcomes?
- How might using utilization review or care management processes, including monitoring following care protocols and policies, for ICC populations provide valuable data?
- How are you using the data collected that's required by contract for follow-up to hospitalization, or following those members with multiple hospitalizations?
- How are you taking a deeper dive on social determinants issues that might be impacting unique populations like those with disabilities, in congregate care settings including populations in LTSS programs, or recently discharged to home after a skilled nursing facility (SNF) stay?
- How are you taking a deeper dive on disparities in underserved minority populations (like seniors for whom English is not primary language who access all sorts of services at much lower rates and have higher burden of chronic disease in Oregon, or populations of color)?
- How are you working with your affiliated MA or DSNP plans to align complex care processes for FBDE duals and identifying high priority goals for both partners to improve member health outcomes? For shared projects we encourage you to consider using both MA/DSNP metrics with your CCO metrics as outcome measures.

15. Utilization Review

Utilization review is the process of reviewing, evaluating and ensuring appropriate use of medical resources and services. The review encompasses quality, quantity and appropriateness of medical care to achieve the most effective and economic use of health care services (OAR 410-120-0000(252)).

TQS projects for this component must:

- Directly link utilization management to quality of care.
- Demonstrate your CCO has mechanisms to detect both under-utilization and over-utilization of services as part of your CCO's quality assessment and performance improvement program (42 CFR 438.330(b)(3)) and describe what those processes are – including work flow, case capture, target goals, second opinions or other procedural reviews.
- Document the utilization review findings, report aggregate data indicating the number of members identified, and describe follow-up actions for findings, including whether the process of utilization management has performed as expected/desired.
- Include broader monitoring activities and context than simply creating a report of utilization. In a first year of a project, the context for creating the report should include the processes described above. In later years, OHA expects to see an explanation of how utilization management has performed over time including changes in case utilization. Explain why the utilization management system of reporting performed as expected or did not meet expectations over time.
- Include trended charts to illustrate changes in utilization with accompanying explanations, particularly for continued projects.

The following are relevant references for this component:

Your CCO shall maintain a health information system that meets the requirements of this contract, as specified in 42 CFR 438.242, and that will collect, analyze, integrate and report data that can provide information on areas including but not limited to utilization of services (CCO Contract Ex B, Pt 7, Sec 1f).