2023 TQS Scoring Criteria

Score of 0 = Relevance scores of zero mean the project did not meet the component-specific requirements; for these projects, detail and feasibility will automatically also score a zero. If a project scores a zero for a component, the CCO will not have the opportunity to resubmit a corrected version and the zero score will be included with the total component and total TQS score.

Score of 1 = Very limited relevance, very limited to not detailed, and very limited feasibility

Score of 2 = Somewhat relevant, somewhat detailed, and limited feasibility

Score of 3 = Fully relevant, fully detailed, and mostly to fully feasible

Relevance **(component specific)**	Project fully addresses the component-specific requirements, as demonstrated by the criteria below.
Detail **(all components)**	**No additional details** or clarity are needed in description, prior year assessment, project context, activities, targets or benchmarks. This includes the following: - A detailed **prior year assessment of the component area** (broader than the specific project) - **Sufficient justification** for why the the project was selected in the project context - For continued projects, the **progress to date** is sufficiently detailed with updates to both activities and targets/benchmarks - Use of **REALD and SOGI data**, or use of REALD and plan for using SOGI data, to identify and address disparities - **Population** for the intervention is clearly defined
Feasibility **(all components)**	Activities, targets, benchmarks and data sources are **mostly to fully feasible** (capable of being carried out) as described, and SMART (specific, measurable, achievable, relevant, time-bound) objectives are utilized. - If continued project: activities and targets/benchmarks are updated OR explained why not. - Activities directly relate to the TQS components selected. - Activities likely to make progress in addressing the gaps identified. - Activities demonstrate meaningful CCO actions throughout the year. - Adequate number of activities to move the project forward in a reasonable time. - Targets/benchmarks are SMART: specific, measurable, achievable, relevant, time-bound

Component-specific requirements

Behavioral Health Integration	**1**	Project demonstrates clear understanding of definition and models of integration.
	2	Project demonstrates integration between behavioral health and physical health and/or behavioral health and oral health.
	3	Project activities cover the continuum of care — prevention, treatment, maintenance and recovery — or cover a part of the continuum of care while clearly demonstrating the project advances integrated care (that is, the project connects individuals to other parts of the continuum of care if indicated).
	4	Project demonstrates how the integration model makes the behavioral health system more equitable (that is, decreases health disparities and improves health outcomes).
	5	Project utilizes the electronic health record/health information exchange system in the infrastructure to support the delivery of integrated care.

Component-specific requirements		
	6	Project implements a care team structure that includes all disciplines involved in the member's behavioral health and primary care.
	7	Project clearly explains 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.
CLAS Standards	1	Project demonstrates the process or actions undertaken to implement at least one of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care (standards 2–15).
	2	Project describes how it is transformative.
	3	Project measures quality improvement over time.
	4	Project advances the provision of effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, multiple languages, health literacy and other communication needs.
	5	Project identifies the primary CLAS standard it is addressing.
	6	Project provides specific details to explain how the project, activities and monitoring address the specific CLAS standard selected.
Grievances and Appeals	1	Project provides grievance and appeal data, including a composite analysis using trend, meta data across the prior year.
	2	Project describes clear plan to improve, including details of the grievance system changes to be instituted based upon the gaps identified in composite analysis.
	3	Project description identifies and describes 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.
	4	Project ultimately focuses on implementing improvements to affect outcomes.
Health Equity: Cultural Responsiveness	1	Project clearly identifies and describes how it addresses quality and/or transformation.
	2	Project clearly identifies goals that are inclusive and equitable.
	3	Project demonstrates consideration of state and federal laws regarding communication and accessibility in the design and implementation.
	4	Project clearly describes how it will improve and/or transform the assistance and support members receive in accessing and navigating the health care delivery system and in accessing and navigating community and social support services and statewide resources.
Health Equity: Data	1	Project clearly describes whether it addresses quality improvement or transformation, and describe why
	2	Project clearly demonstrates how the CCO will use REALD and SOGI data to support efforts to eliminate health disparities and provide culturally and linguistically responsive services.
	3	Project clearly demonstrates an operational understanding of the need and use of demographic data collection and analysis in advancing health equity.

Component-specific requirements		
	4	Project clearly demonstrates the CCO has developed and adopted, or plans to develop and adopt, processes that allow the stratification of quality data by race, ethnicity, language and disability.
Oral Health Integration	**1**	Project allows members to receive targeted non-oral health care (such as diabetes, hypertension and tobacco screenings) and referrals from a dental provider **OR** oral health care and referrals in their primary care or behavioral health provider's office.
	2	Project allows members to access oral health care outside of the traditional dental office.
	3	Project enables dental providers to share member health information with primary care and behavioral health professionals through health information technology.
Patient-centered Primary Care Home: Member Enrollment	**1**	Project describes 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
Patient-centered Primary Care Home: Tier Advancement	**1**	Project describes comprehensive plan to support PCPCH practices 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.
Severe and Persistent Mental Illness	**1**	Project demonstrates 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.
	2	Project clearly supports self-determination and patient-centeredness.
	3	Project demonstrates clear commitment to providing services in the most integrated setting.
	4	Project includes a report of aggregate data indicating the number of members identified and methods used.
	5	Project is clearly informed by social determinants of health.
	6	Project focuses on improving patient outcomes.
Social Determinants of Health and Equity	**1**	Project provides clear evidence or plan for member engagement to develop and/or inform project and/or broad strategy.
	2	Project addresses social needs at a community level, beyond working with individual members, through collaboration between the health care system and community partners.
	3	Project shows how how community needs and priorities were considered in development the project.
	4	Project provides clear evidence or plan to collaborate with community partner(s).
	5	Project addresses one or more of the four key SDOH-E domains.
Special Health Care Needs: Full Benefit Dual Eligible Population	**1**	Project identifies a population within your FBDE members with SHCN for which you are seeking to improve health outcomes.
	2	Project utilizes evidence-based or innovative strategies to ensure your identified population has access to integrated and coordinated care.
	3	Project primarily focuses on quality improvements related to improving health outcomes for your identified SHCN population.
	4	Project clearly identifies and monitors health outcomes for your identified SHCN population.

Component-specific requirements		
	5	Project demonstrates collaboration with affiliated Medicare Advantage Plan.
Special Health Care Needs: Non-dual Medicaid Population	**1**	Project identifies a population within your non-FBDE Medicaid members with SHCN for which you are seeking to improve health outcomes.
	2	Project utilizes evidence-based or innovative strategies to ensure your identified population has access to integrated and coordinated care.
	2	Project primarily focuses on quality improvements related to improving health outcomes for your identified SHCN population.
	4	Project clearly identifies and monitors health outcomes for the prioritized population.
Utilization Review	**1**	Project directly links utilization management to quality of care.
	2	Project demonstrates 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 and describes what those processes are – including work flow, case capture, target goals, second opinions or other procedural reviews.
	3	Project documents the utilization review findings, reports aggregate data indicating the number of members identified, and describes follow-up actions for findings, including whether the process of utilization management has performed as expected/desired.
	4	Project demonstrates your CCO has mechanisms to actively monitor utilization of services over time, and includes trended charts to illustrate changes in utilization with accompanying explanations, particularly for continued projects.
	5	Project demonstrates the project is a result of the CCO's broader monitoring activities, including a macro analysis of the CCO's over-utilization and under-utilization compared to the availability of services. The project will include a plan for monitoring and improving utilization management over time. In the first year of a project, the context for creating the utilization 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. In the TQS project, explain why the utilization management system performed as expected or did not meet expectations over time.