Sample Transformation and Quality Strategy (TQS)

This sample TQS is meant to provide examples of potential TQS strategies addressing various TQS components. The table of contents below will help you navigate through the document.

Contents

Section 1: Transformation and Quality Program Information

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

i. Describe your CCO's quality program structure, including your grievance and appeal system and utilization management review:

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

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

Utilization: ExampleCCO utilizes a variety of methods to detect both under- and over-utilization of services. One method used is cost and utilization reports, which show how services are being utilized by ExampleCCO members by county and compared to other CCOs. The reports are reviewed monthly in the utilization review committee. Additionally, the reports and analysis are provided to each of our eight local community advisory councils (LCACs), our clinical advisory panel and board of directors. Each of these groups has a vested interest to increase and decrease utilization as appropriate.

Grievance/Appeal System: ExampleCCO and our partners process OHP complaints and appeals according to the Oregon Administrative Rules (OARs). We log complaints and appeals (medical, dental, pharmacy, behavioral health), whether received in writing or by telephone, into our OHP grievance database and report cases to the OHA Health Systems Division. We established a dedicated Medicaid customer service (MCS) team in Q4 2016 for monitoring and analyzing complaint data over time. The appeal supervisor is responsible for performing root-case analysis when areas of poor performance are identified by the MCS team. Corrective actions are submitted to our Medicaid compliance officer for review, approval and monitoring.

ii. Describe your CCO's organizational structure for developing and managing its quality and transformation activities (please include a description of the connection between the CCO board and CAC structure):

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

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

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

iv. Describe how your CCO is working with community partners (for example, health systems, clinics, community-based organizations, local public health, community mental health programs, local government, tribes, early learning hubs) to advance the TQS:

As a partner in the community, ExampleCCO believes in a bi-directional relationship to further our community's health. ExampleCCO works with community systems for delivery of care, communication to members, strategic planning insights, and the development of cross-agency initiatives to improve the health of our community. For example, ExampleCCO works with the local public health WIC program, community-based organizations for maternal health, and the two community health centers who provide XX% of maternal care in XX county/ExampleCCO region. Additional details of areas of cross collaboration are in section II by component area.

B. Review and approval of TQS

i. Describe your CCO's TQS development process, including review, development and adaptation, and schedule:

ExampleCCO's QIC meets at least quarterly. Specifically, at a minimum, the QIC is responsible for the following: assuring compliance with quality assurance and performance improvement provisions of ExampleCCO's contract with OHA; annually evaluating our effectiveness in achieving objectives within work plans; collecting annual satisfaction surveys from community partners and stakeholders; reviewing CCO quality measures at least quarterly; annually reporting performance improvement projects and focus areas; and sharing semi-annual quality reports with our board of directors. The QIC performs annual evaluation of QAPI system activities, reports via the annual TQS and adjusts quality and transformation work to improve gaps determined during evaluation. Annual evaluation will include QAPI Federal requirements and QAPI contract requirements (Ex B, part 9, section 2d), and will meet the objectives of OHA's 1115 Medicaid waiver requirements for health transformation. Throughout the year, the QIC reviews the developed work plans from the TQS to monitor progress. Additionally, the QIC is responsible for the overall submission of the annual TQS; which is used to move health transformation and implement and ensure quality coordinated health care, including behavioral health and dental care. ExampleCCO's medical director and quality director present the annual TQS to ExampleCCO's board of directors for adoption.

C. OPTIONAL

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

No specific example provided; of note this optional information is for providing OHA the context of regional priorities, CCO strategic approach and connection to quality, geographic regions and limitations, and enrollment demographics.

Section 2: Transformation and Quality Program Details

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

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

B. **Primary component addressed**: Access

i. Secondary component addressed: Utilization review
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Access: Cultural considerations

i. Additional subcomponent(s) addressed: None

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

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

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

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

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

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Interpretive services utilization

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2.5/clinic/quarter	TBD	4/2018	TBD	4/2020

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

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

B. **Primary component addressed**: Access

i. Secondary component addressed: Health equity
ii. Additional component(s) addressed: PCPCH

C. **Primary subcomponent addressed**: Access: Timely access

i. Additional subcomponent(s) addressed: Health equity: Data

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

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

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

Evaluation Analysis

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

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

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

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

Tracking and trending of key indicators.

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

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

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

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

☒ Short term or ☐ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Metrics not identified and segmented	Metrics list and segmentation completed	3/2019	Metrics list and segmentation completed	3/2019

Monitoring activity 1 for improvement: Metrics tested and dashboard developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Metrics tested and dashboard developed	No dashboard	Dashboard developed	6/2019	Dashboard developed

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

☒ Short term or ☐ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current interventions to address gaps.	Two gaps identified	6/2019	Work plans developed	9/2019

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No metric identified	Metric for each gap identified	9/2019	Metric improved by X%	12/2019

Activity 3 description: Develop maternal care team

☒ Short term or ☐ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No maternal care team in place	Maternal care team identified	9/2019	Maternal care team trained and implements intervention	12/2019

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

☐ Short term or ☒ Long term

Monitoring activity 4 for improvement: Referral system developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No referral system	Referral system developed	12/2019	Referral system developed	12/2019

Monitoring activity 4 for improvement: Referral system tested

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No referral system	Referral system tested	6/2020	Referral system tested	6/2020

Monitoring activity 4 for improvement: Referral system implemented

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

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

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

B. **Primary component addressed**: Access

i. Secondary component addressed: Special health care needs
ii. Additional component(s) addressed: Integration
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☒ Oral health integration

C. **Primary subcomponent addressed**: Access: Timely access

i. Additional subcomponent(s) addressed: None

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

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

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

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

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

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

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Dental care wait times (all CCO members)

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
X weeks for standard dental care	TBD	9/2018	Average wait times for SHCN members is	4/2021

			equal to CCO member average ±5%	

A. **Project or program short title**: Health Equity Project 1: Communication and language assistance services implementation plan

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

B. **Primary component addressed**: Health equity

i. Secondary component addressed: CLAS standards and provider network
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Health Equity: Cultural competence

1. Additional subcomponent(s) addressed: None

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

As Oregon's population becomes ever more diverse, health care providers serve increasing numbers of members from diverse cultural and linguistic backgrounds. Culture and language play a crucial role in how effectively health services are delivered and received. Issues such as member engagement, health care literacy and English language proficiency are all factors that providers must consider to provide culturally competent care. The provision of accessible and meaningful language services to individuals with limited English proficiency (LEP) is a key component of health equity.

There are currently gaps in availability and access to health care interpretation, with less than 15% of members that identify primary languages other than English and have LEP having accessed a health care interpreter

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

Communication and Language Assistance Services Implementation Plan:

ExampleCCO will develop a plan that will allow the CCO and our network health care providers to:

1. Ensure members receive culturally and linguistically appropriate care.
2. Ensure CCO and providers are able to have clear and open communications with members.
3. Ensure network providers know how to access health care interpretation.
4. Ensure CCO and network providers are in compliance with state and federal laws.
5. Ensure CCO and network providers are aligned with "communication and language assistance" CLAS standards.

Governance, leadership and workforce

1. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
2. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
3. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

To ensure further organizational alignment with CLAS beyond "communication and language standards," CCO will engage the community advisory council and providers to meet CLAS "governance, leadership and workforce" standards.

We expect to develop the language access implementation plan by September 2019 and adopt and implement it by March 2020.

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

Activity 1 description: This language plan is developed based on the CLAS framework of 16 standards along with consumers and community members, in addition to plan and clinic leadership. It includes the allocation of funds for language services and guidance on the provision of such services that include:

- Demonstrating organizational commitment to workforce diversity by hiring and retaining staff to match the language and culture of the communities served
- Using qualified and/or certified health care interpreters
- Using telephonic or video interpreting and contracting with agencies that employ them
- Understanding how to use interpreter services and the different modalities (with the interpreter present or via phone or video) and considering patient/members preferences
- Providing language services to members who have limited English proficiency and/or other communication needs such deaf or hard of hearing
- Providing language services at no cost to members to facilitate timely access to all health care and services
- Ensuring language services are provided by trained health care interpreters and not by ad-hoc interpreters such as family or by other staff, unless staff is a trained and qualified or certified medical interpreter
- Ensuring the difference between health care interpreter and bilingual employee is understood
- Ensuring the quality of language services provided

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Plan is developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current plan	Plan is developed	09/2019	Plan is developed	09/2019

Monitoring activity 1 for improvement: Plan is implemented

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No current plan	Plan is implemented	03/2020	Plan is implemented	03/2020

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

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

☐ Short term or ☒ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
30%	75%	12/2019	100%	12/2020

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
14.2%	75%	12/2019	100%	12/2020

A. **Project or program short title**: HIT Project 1: Implementing a population health management tool to identify patients at risk of hypertension

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

B. **Primary component addressed**: Health information technology

i. Secondary component addressed: Choose an item.
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: HIT: Analytics

i. Additional subcomponent(s) addressed: None

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

ExampleCCO performance Our data suggests (XX%) that we have a significant number of members with undiagnosed hypertension and that we are missing opportunities to improve high blood pressure control as a result. We intend to improve hypertension diagnosis and care management opportunities by providing risk score information to providers and care managers. We will measure success by improvement in the quality measure for controlling high blood pressure.

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

ExampleCCO will use a population health tool from XYZ Vendor to identify patients with elevated blood pressure without a hypertension diagnosis. We will focus on patients who may be at risk of hypertension or have undiagnosed hypertension in order to support improved diagnoses and care management.[1] The XYZ tool will use member data from network providers' EHRs and CCO administrative and claims data to identify patients at risk. Risk score information will be returned to the providers and care managers.

For the initial project, we will onboard five clinics to the population health management tool. We will use the initial experience to assess the usefulness of the tool and adjust as needed. In later phases, we intend to expand to more clinics in the CCO network and additional use cases.

[1] ExampleCCO could address another component or subcomponent in this project. For instance, this project could also include a health IT – HIE component where an HIE is used to transmit the data or to host a population management tool. This project also could incorporate an analysis of disparities to support combining with a health equity component.

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

Activity 1 description: Onboard 5 clinics to XYZ Vendor population health management tool

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: # of clinics onboarded

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	5	5/2019	5	05/2019

Activity 2 description: Participating clinics and care managers use population health tool to access information and identify patients for follow-up

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: # of clinics using population health tool to access patient information at least biweekly

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	5	7/2019	5	07/2019

Activity 3 description: CCO monitors clinics' performance on NQF0018/CMS165

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Improvement in quality measure for controlling high blood pressure (NQF0018/CMS 165).

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
NQF0018/ CMS165 performance for each clinic as of 12/18	CCO 2019 benchmark (TBD 2018 national Medicaid 90th percentile)	09/2019	CCO 2019 benchmark (TBD 2018 national Medicaid 90th percentile)	12/2019

A. **Project or program short title**: HIT Project 2: Supporting behavioral health agencies to participate in community-based health information exchange

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

B. **Primary component addressed**: Health information technology

i. Secondary component addressed: Integration of care (physical, behavioral and oral health)
ii. Additional component(s) addressed: Value-based payment models
iii. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: HIT: Health information exchange

i. Additional subcomponent(s) addressed: None

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

Analysis of our data shows that our members with a mental illness diagnosis seek care through emergency department visits at a much higher rate than members without such diagnoses. By connecting behavioral health providers to HIEs, we can enable behavioral health and physical health providers to provide better care coordination and referrals for whole person care. Anecdotal evidence has shown that hospital care coordinators who have used health information exchange in other settings have been able to identify behavioral health and primary care providers supporting the member and helped the hospital intervene with members and connect them to care services in more appropriate settings.

By providing subsidies to behavioral health providers to participate in HIE entities, we will increase the capacity for care coordination, transitions of care, and referrals between behavioral health and physical health entities.

ExampleCCO will monitor the uptake of subsidies by the identified critical behavioral health organizations. We will also monitor the active participation of behavioral health entities with HIE. Lastly, and recognizing that multiple factors inform the utilization of emergency departments, particularly for members with a mental illness diagnosis, we will track emergency department utilization to see if there is a shift in use. However, given the many factors that determine emergency department utilization, the primary evaluation of the success of this project will be on the uptake of subsidies and the active bi-directional data exchange by the critical behavioral health organizations.

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

ExampleCCO will implement a program to financially support critical behavioral health agencies to participate in XYZ community-based health information exchange (HIE) including: certified community behavioral health clinics (CCBHCs), community mental health programs (CMHPs), assertive community treatment (ACT) teams, and mobile crisis teams. One of the major barriers to behavioral health providers' participation in the community-based HIE has been financial cost. This program will help address that barrier.

ExampleCCO is focusing on these specific organizations to work toward our larger goal of reducing disparities in emergency department utilization by members with mental illness. HIE participation allows providers to share a broad range of health information via community health records, eReferrals and/or results delivery. Although this project focuses on financial support for EHR-to-HIE connections, HIE connectivity training, and ongoing HIE costs, XYZ community-based HIE allows any provider to participate, regardless of EHR or lack of EHR. By connecting critical behavioral health providers to our XYZ community-based HIE, the program will increase data exchange and coordination of care between behavioral health and physical health providers (particularly hospital and primary care), and will support the information sharing necessary for other specific initiatives underway around integration of physical and behavioral health. We expect improved coordination to help to decrease inappropriate utilization of emergency department services by members who have a mental illness diagnosis.

By the end of the program, 90% of identified critical behavioral health providers will have onboarded to an HIE, and 90% of those onboarded will have actively participated in bi-directional health information exchange by contributing data to the HIE's community health record. Longer term, we will establish targets and benchmarks for sustained participation in HIE

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

Activity 1 description: Identify behavioral health agencies who face financial barriers to participation in community-based HIE and determine what type of subsidies would have the greatest impact on participation for those providers.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: % of CCBHCs, CMHPs, ACT teams and mobile crisis teams that have been evaluated for HIE subsidy program

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	100%	12/2019	100%	12/2019

Activity 2 description: Provide subsidies to identified BH agencies.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: % of CCBHCs, CMHPs, ACT teams and mobile crisis teams identified for subsidy program participation that received subsidies

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	50%	03/2020	90%	12/2021

Activity 3 description: Track ongoing participation in community-based HIE post-subsidy.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: % of CCBHCs, CMHPs, ACT teams and mobile crisis teams that received subsidies and participated in community-based HIE for at least one year

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	50%	03/2021	90%	03/2022

Monitoring activity 3 for improvement: % change in emergency department utilization by members with a mental illness diagnosis in one year assigned to behavioral health agencies participating in HIE

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	-0.5%	03/2021	-1%	03/2022

A. **Project or program short title**: HIT Project 3: Improving diabetes prevention and control through an interactive text platform

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

B. **Primary component addressed**: Health information technology

i. Secondary component addressed: Choose an item.
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: HIT: Patient engagement

i. Additional subcomponent(s) addressed: None

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

In review of ExampleCCO claims data it suggests that we have a significant number of members presenting as pre-diabetic and that we have an opportunity to engage them in an early intervention to try to reduce their blood glucose levels. We intend to reduce the number of members who move from pre-diabetic to diabetic by engaging them in their care and monitoring of levels and activities that could reduce their likelihood of becoming diabetic.

Medicaid patients who have used the Wellpass Care4Life app in other settings have seen a drop in blood glucose, achievement of additional wellness goals, reduced hospitalizations, improved medication adherence, and fewer urgent care visits.

ExampleCCO will monitor members with a pre-diabetic condition without moving to diabetes, and those whose blood glucose levels move from pre-diabetic to normal range to see if the program assists in improving health outcomes.

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

To facilitate patient engagement with their care, members diagnosed with pre-diabetes and Type 2 diabetes will receive ExampleCCO assistance to sign up for a Lifeline phone, provided by the federal government. Once members have received the phone, CCO will assist with enrollment in Wellpass, an interactive text platform that provides application-based support for different health concerns.

ExampleCCO will identify members diagnosed as pre-diabetic and will assist members to sign up for Care4Life, an application that supports patients in managing their pre-diabetes. Members will be provided information and initial training with how to use the platform. There will be a check-in at six months and one year to see how participants are responding to the platform. Quantitative data will be available from the system itself. Qualitative data will be available from surveys and in-person conversations with the members.

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

Activity 1 description: Assist members diagnosed with pre-diabetes with getting Lifeline phones.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Number of eligible pre-diabetic members who have received phones

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	50	6/2019	100	9/2019

Activity 2 description: Assist pre-diabetic members with enrolling in Wellpass and the Care4Life app.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Number of members enrolled in Care4Life

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	40	6/2019	80	9/2019

Activity 3 description: Monitor Care4Life utilization.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Number of patients actively interacting with Care4Life

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0	35	6/2019	70	3/2020

Activity 4 description: Monitor blood work on patients to determine blood glucose levels.

☒ Short term or ☐ Long term

Monitoring activity 4 for improvement: Blood glucose results from patients enrolled in Care4Life

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
TBD	Same as baseline or better	6/2019	Same as baseline or better	9/2019

A. **Project or program short title**: Integration Project 1: Dental care referrals in behavioral health settings

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

B. **Primary component addressed**: Integration of care (physical, behavioral and oral health)

i. Secondary component addressed: Severe and persistent mental illness
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☒ Behavioral health integration ☒ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

i. Additional subcomponent(s) addressed: None

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

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

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

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

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

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

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Oral health survey developed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Survey in development	Survey developed	06/2019	Survey developed	06/2019

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

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: BH professionals trained

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Training in development	Training provided	09/2019	Training provided	09/2019

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

☐ Short term or ☒ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0% consistent use	75% consistent use	12/2020	100% consistent use	12/2021

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
48%	60%	12/2020	75%	12/2021

A. **Project or program short title**: VBP Project 1: Value-based risk payment model

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

B. **Primary component addressed**: Value-based payment models

i. Secondary component addressed: Patient-centered primary care home
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

i. Additional subcomponent(s) addressed: None

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

Experience has shown providers are more motivated to make changes in how they deliver care when they assume risk of loss.

Providers share savings if cost of services are below a pre-determined risk-adjusted budget and share losses, if above. Budget is based on total cost of care for most covered services. High-cost outliers are excluded.

Motivate clinicians and institutions to change the way they deliver care to reduce cost growth, improve health care quality and population health.

ExampleCCO will continue to implement a value-based risk payment model targeting regional hospitals, patient-centered primary care home clinics, primary care physicians (PCPs) and independent physician associations (IPAs) to improve budget performance

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

ExampleCCO has a current value-based payment model, which includes risk payments, in which the CCO shares risk on overall CCO performance with voluntarily participating hospitals, patient-centered primary care home clinics, primary care physicians and independent physician associations.

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

Activity 1 description: If the ExampleCCO performs better than budgeted, the CCO distributes 77% of the surplus using an agreed upon formula (some funds are reserved for quality performance bonuses)

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monthly reporting. Budget is based on total cost of care for most covered services. High-cost outliers are excluded.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
5 regional hospitals participating, three out-of-area hospitals, and ~60% of medical clinics are participating in this model.	5 additional regional hospitals agree to participate, 2 additional out-of-area hospitals participating, and annual increase of 25% of medical clinics participating in this model.	1/2019	All 10 regional hospitals, 85% out-of-area hospitals participating, and ~85% of medical clinics are participating in this model (% of appropriate provider groups – must have a large enough patient population).	1/2020

A. **Project or program short title**: SDOH Project 1: Social determinants of health screening and referral pilot

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

B. **Primary component addressed**: Social determinants of health

i. Secondary component addressed: Choose an item.
ii. Additional component(s) addressed: None
iii. If *Integration of Care* component chosen, check all that apply:
☐ Behavioral health integration ☐ Oral health integration

C. **Primary subcomponent addressed**: Choose an item.

i. Additional subcomponent(s) addressed: None

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

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

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

Five of ExampleCCO's participating clinics—that voluntarily choose to participate—will implement social determinants of health screening at primary care visits using ExampleTool. This pilot will prioritize families with children under the age of 5, including screening at well-child visits. Screening is intended to identify families in need of community services, and clinic staff will connect families in need with community resources. Resource navigation staffing will be added at the clinic level. These staff will be supported by CCO-level HIT infrastructure that includes health information exchange technology that enables electronic referrals between health care, public health, oral health, behavioral health, and social service agencies.

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

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

☒ Short term or ☐ Long term

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

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 staff trained	75% of designated staff trained	ExampleDate	100% of staff trained	ExampleDate

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

☒ Short term or ☐ Long term

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

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

Section 3: Required Transformation and Quality Program Attachments

A. Attach your CCO's quality improvement committee meeting minutes from three meetings

B. Attach your CCO's consumer rights policy

C. OPTIONAL: Attach other documents relevant to the above TQS components, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.