The Oregon Health Authority recognizes that the projects included in the CCO Transformation and Quality Strategy (TQS) 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's (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 generally expected to carry over projects from the prior year, unless they have met their expected goals or other discontinuation criteria. CCOs must update continued projects each year with progress to date and new activities.

Timeline and assessment

Your CCO must submit its **2024 TQS by July 15, 2024**, via the CCO Contract Deliverables Portal. (The submitter must have an OHA account to access the portal.) Please combine all pieces of your submission into one PDF with a table of contents.

OHA will provide feedback to each CCO on their submission. CCOs are expected to use the OHA feedback to improve their quality improvement work.

CCOs will receive a written assessment with their scores and OHA feedback by August 30. This information will be delivered via the CCO Contract Deliverables Portal, with a results letter indicating approval or corrections needed.

For OHA to approve your TQS submission, it must meet the following:

- Use the current year's TQS template.
- Include at least one project that addresses each of the nine components.
- Targets and benchmarks are updated for the current year.

When the TQS is approved, the results letter will provide the due date and instructions for submitting the redacted TQS and redaction log.

If the TQS submission is not approved, the results letter will provide the due date for resubmitting the TQS to OHA.

All CCOs have the option to have a feedback call with OHA to discuss their written assessment and areas of improvement.

Resources and contact information

All TQS guidance documents and resources for 2024 will be posted by February 1, 2024, 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@odhsoha.oregon.gov).

Instructions

Please combine all pieces of your submission into one PDF with a table of contents, and follow the file naming convention: "CCO Name-2024 TQS". (See how to insert a table of contents.)

Section 1: Transformation and quality project details

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

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

Repeat the TQS project details (Section 1, Parts A–E) until all components have been addressed. CCOs can address up to three components per project, where applicable. Insert additional Parts A–E as necessary. One project per component is required, but CCOs may submit additional projects. OHA recommends CCOs submit no more than two or three projects per component. This helps the CCO focus their work and avoid unnecessary reporting. A project must meet component guidance for every component the CCO assigns to it, and OHA will assess the project separately for each component assigned using TQS scoring criteria.

If you are submitting a duplicate project for more than one CCO, indicate whether the projects are identical or differentiated (and if so, how they are different). At a minimum, OHA expects the data to be specific to the region and members served.

Continuing projects: Your CCO is generally expected to carry over projects from the prior year, unless they have met their expected goals or other discontinuation criteria (see below). CCOs must update continued projects each year with progress to date and new activities. It is essential for CCOs to demonstrate progress year over year to meet the transformation goals set across TQS components and move the health system forward. Continuation projects will be reviewed with an eye for performance over time.

Questions to consider:

- Are you moving the work to meet member and community needs?
- Does the continued project demonstrate 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.

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 requirements, which ensure health transformation and quality for Medicaid members, for the chosen component(s) based on OHA feedback and/or written assessment.

In 2024, CCOs will not need to report on or close out discontinued projects from the prior year.

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 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 (see project ID list)

B. Components

- ✓ Choose up to three components from the dropdown menus that this project addresses. All nine components must be addressed at some point in the TQS. OHA will assess the project separately for each component attached.
- ✓ If this project includes aspects of health information technology (HIT), select the appropriate check box. Check "yes" if the project includes HIT as a core component, such as supporting provider electronic health records, new functionality or tools for the CCO to be sharing data with their providers or other partners, new use cases for data sharing or HIE tools, new or expanded use of the CCO's population management/analytics tools, etc.
- ✓ If CLAS Standards is selected as a component, select the primary CLAS standard being addressed from the dropdown.

C. 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. This may include narrative, tables and charts (for example, gap analysis, driver diagrams, fishbones, prioritization matrices). While this project may not address all gaps identified, the project should be a starting point in moving the component area's health system transformation forward and/or serve as a building block to your CCO's organizational and quality efforts for the component area. Include details about how this project addresses unique characteristics, identified needs and service gaps of your community, members, targeted population for the project, or network providers.
- ✓ **If this project is continued from the prior year, describe progress to date** as demonstrated by 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.
- ✓ **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.
- ✓ **Include REALD (race, ethnicity, language and disability) and GI (gender identity) data for 1) identifying and 2) addressing disparities.** The REALD & GI requirement applies to all member-level data used in the TQS. For more guidance, see the "REALD & SOGI requirements across components" section of this guidance document.

D. Brief narrative description

- ✓ Define the population for the intervention. Consider focusing on one or more priority populations. These populations would include:
  - Members in priority populations as defined by Regional Health Equity Coalitions (OAR 950-020-0010): communities of color; Tribal communities including the nine federally recognized tribes of Oregon and other American Indians and Alaska Natives people; immigrants; refugees; migrant and seasonal farmworkers; low-income individuals and families; persons with disabilities; and individuals who identify as lesbian, gay, bisexual, transgender or queer, or who question their sexual or gender identity.
  - Members in life transitions, as defined in Oregon's 1115 Medicaid waiver; and
  - Communities experiencing health disparities (as identified in the CCO's community health assessment or REALD & GI data analysis).
- ✓ Write a brief, high-level description of the project intervention(s) to be implemented (or in progress). 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. This intervention description can be higher level than the activities described in Section E. Do not repeat project rationale in this section. Rationale is reported in Section 1 Part C.

E. 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, targets/benchmarks and dates accordingly. If they haven't changed since the prior year, explain why in the project context (Section C).

- ✓ **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 and to the specific rationale and project description. 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).
    - Write activities as specific, measurable, achievable, realistic and time-bound (SMART). Your CCO is encouraged to go further and use SMARTIE goals (SMART plus inclusive and equitable). See more information about adding inclusion and equity to SMART goals.
    - 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.
    - Describe how the activity 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.
    - If the CCO has identified disparities by REALD & GI categories, include activities, measures, targets and benchmarks to address and monitor those disparities.
- ✓ **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 end of the calendar year, 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. Long-term activities might link to the CCO's goal to improve a CCO metric over time.
- ✓ **Monitoring measure**: 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. Each activity must have at least one monitoring measure. 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 measures by inserting additional monitoring descriptions as needed to capture measures of success.

- If monitoring measures use member-level data, disaggregate results by granular REALD & GI categories to track progress in eliminating disparities.

✓ **Baseline or current state**: This is the 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. 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 your 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.

- If your targets are tracking member-level data, disaggregate results by granular REALD & GI categories for any disparities you're trying to eliminate.
- Define your target/future state consistent with SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive, equitable) objectives. More information about SMART goals is available through the Minnesota Department of Health.
- For more information about adding inclusion and equity to SMART goals, see this SMARTIE goals worksheet.

✓ **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 2024, write 12/2024. Based on the submission timeline, some targets may have already been reached by time of submission.

✓ **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.

- If your benchmarks are tracking member-level data, disaggregate results by granular REALD & GI categories for any disparities you're trying to eliminate.
- Define your benchmark/future state consistent with SMARTIE (specific, measurable, achievable, relevant, time-bound, inclusive, equitable) objectives. More information about SMART goals is available through the Minnesota Department of Health.
- For more information about adding inclusion and equity to SMART goals, see this SMARTIE goals worksheet.

✓ **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 2025, write 12/2025.

Section 2: Supporting information (optional)

Supplemental documentation is not intended to replace analysis or a comprehensive response within the TQS. Project-specific supporting information could include but is not limited to:

- ✓ Component or project-focused driver diagrams
- ✓ Root-cause analysis diagrams
- ✓ Data to support project problem statements
- ✓ Member-facing materials created for the project

All project-specific supplemental documents *must* reference which project the document is supplementing. This must be noted in both the TQS template for that project *and* the supplemental document's content.

- ✓ Combine the TQS submission and all attachments into a single PDF.
- ✓ Reference any attachments in the table of contents.

REALD & SOGI requirements across components

To achieve health equity requires high-quality REALD (race, ethnicity, language and disability) and SOGI (sexual orientation and gender identity) data; without it there is no effective means for identifying where inequities exist. CCOs must be mindful that quality improvement may not benefit all populations equally. Careful measurement is vital to improving equity. Without REALD & SOGI data analysis, disparities and inequities within and across member groups in health and service delivery go unnoticed, even as CCOs seek to improve services.

Your CCO shall adopt processes that allow stratification of quality data by members' REALD & SOGI in every area of the organization as a tool for uncovering and responding to health care disparities and inequities. For more resources, see OHA's REALD & SOGI implementation page.

TQS projects that use CCO member-level data need to use REALD & GI (race, ethnicity, language, disability and gender identity) data for identifying disparities and designing activities to address those disparities. Note: While TQS requirements will be moving toward using full SOGI (sexual orientation and gender identity) data, CCOs don't yet have access to member-level sexual orientation data. For 2024, TQS will focus on the gender identity portion of SOGI. CCOs are also asked to report on their plans for using sexual orientation data from OHA (when available) or such data from other sources.

TQS projects that use member-level data must:

- ✓ Analyze all aspects of REALD & GI
- ✓ Identify any disparities
- ✓ Include project activities to address those disparities
- ✓ Include policy or programmatic recommendations to address any inequities identified
- ✓ Disaggregate member-level targets and benchmarks by REALD & GI categories
- ✓ Describe a plan for using sexual orientation data when it's available

TQS projects that use member-level data must:

1. **Analyze REALD & GI data to identify disparities** (project context).
   - ✓ Demonstrate that full analysis has been completed at the most granular level possible.
     - Include at least a statement that all elements were analyzed, and then more detail (data or findings) on the disparities identified and prioritized for intervention. OHA doesn't need to see the full analysis, but will need to understand what the CCO looked at, what the CCO found, where the CCO decided to focus for intervention, and why.
   - ✓ Analyze every element of REALD & GI. (For example, a project that analyzes race, ethnicity and language but not disability or gender identity will not earn full points. Consider doing intersectional analysis of REALD & SOGI data to better uncover disparities.)
   - ✓ Identify disparities or gaps across REALD & GI categories at the most granular level possible.
   - ✓ Include only actual data that's relevant to the project.
     - OHA expects CCOs to collect and analyze REALD & SOGI data at the most granular level possible (for example, Chinese, Korean, Japanese, etc. instead of "Asian").
     - CCOs may develop interventions for small populations, but use discretion in reporting numbers for such groups to ensure they protect confidentiality.
     - For TQS reporting, especially those projects focusing on smaller populations, CCOs may need to roll up the data into intermediate or "parent" categories. If this is the case,

describe why in the context of the project and how doing so addresses the gaps identified.

2. **Use REALD & GI data to address disparities** (project context, activities, measures).
    - If disparities were identified for the project population, include project activities and measures to address those disparities.
    - If inequities were identified for the project population, include specific policy and programmatic recommendations to address the inequities.
    - For sexual orientation (SO) data, at a minimum, describe your CCO's plan for using SO data to identify and address disparities once the data is available. SOGI standards are expected to be available through Oregon Administrative Rule in spring 2024. OHA's timeline for integrating all SO questions into the eligibility application and then releasing SO data is unknown.
3. **Track member-level measures by disaggregated REALD & GI categories** (monitoring measures, targets, benchmarks).
    - If the project includes activities to address disparities, include targets and benchmarks that are disaggregated by granular REALD & GI categories to monitor progress.

REALD & GI component-specific guidance

The REALD & GI requirement is only tied to any CCO member-level data that is involved in the project. For the following components, the REALD & GI requirement may or may not apply depending on the project:

- **PCPCH: member enrollment** – If your CCO uses individual criteria to assign members to a PCPCH, your TQS project for this component needs to use REALD & GI data (and have a plan for using sexual orientation data). If your CCO does not use individual criteria for assigning members to PCPCHs, the REALD & GI requirements won't apply to your TQS project for this component.
- **PCPCH: tier advancement** – If your CCO uses member-level data to prioritize or plan tier advancement supports for clinics, your TQS project for this component needs to use REALD & GI data (and have a plan for using sexual orientation data). If your CCO doesn't use member-level data to prioritize or plan tier advancement support for clinics, the REALD & GI requirements won't apply to your TQS project for this component.

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 and implement; examples are not an exclusive or exhaustive list.

1. 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. If applicable to your CCO's project, OHA encourages including technical assistance for your CCO's delivery system focused on integrated behavioral health payment models, including the new billing code and modifiers for integrated services.

TQS projects for this component must:

- Demonstrate clear understanding of definition and models of integration;
- Demonstrate integration between behavioral health and physical health and/or behavioral health and oral health, including but not limited to integrated setting, care coordination, or transitions of care;
- 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);
- Demonstrate how the integration model makes the behavioral health system more equitable (that is, decreases health disparities and improves health outcomes);
- Utilize the electronic health record/health information exchange system in the infrastructure to support the delivery of integrated care;
- 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 primary care services in behavioral health settings. For example, any of the following activities in a behavioral health setting would be considered integration:
    - Tobacco cessation for people with severe mental illness
    - Diabetes self-management and monitoring for diabetes
    - Screening for metabolic syndrome for all clients on an anti-psychotic medication
    - Offering all preventive screenings such as colonoscopies or mammograms for individuals with severe mental illness
    - Hiring a primary care provider in a community mental health program
- Allow members to receive behavioral health services in a primary care setting (for example, providing depression screening in a primary care setting.
- 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.
- Provide technical assistance for use of billing codes and/or modifiers for improving integrated services.
- Develop and implement plans, through collaboration between the behavioral health community and physical health or oral health, 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.
- Improve coordination of care between the behavioral health system and primary care provider. In particular, projects should focus 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.

Considerations 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?

2. 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 CLAS Standards Blueprint is a central guidance document for CCOs and their provider networks on how to implement sustained CLAS Standards to address inequities at every point where the CCO member has contact with the health care system. The CCO contract requires that CLAS Standards are implemented and sustained as a part of a CCO's foundation and operations.

Projects for this component will help 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 sustained incorporation of CLAS standards in every aspect of the CCO and provider network is the primary long-term goal. 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.

TQS projects for this component must:

- Provide specific details to explain how the project, activities and monitoring address the specific CLAS standard selected. OHA will be comparing the CCO's response to the standard as detailed in the CLAS Blueprint.
- Describe how the project is transformative – that is, how it focuses on fostering innovative, transdisciplinary, culturally and linguistically responsive and impactful projects and programs to improve the health of OHA priority populations.

- Describe how the project moves toward a health care delivery system that improves access, experience and outcomes for people living in Oregon who communicate in languages other than English. This includes supporting people with disabilities.
- Describe how the project measures quality improvement over time. Quality improvement is the framework used to systematically improve health care and services.
- Describe how the 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 for people with disabilities.

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 and all network providers for consistently informing people 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 should 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).

Considerations 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?

3. Health Equity: Cultural Responsiveness

This component refers 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 from a quality and transformation perspective.

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, age, 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.

- **Quality improvement** is the framework used to systematically improve health care and services.
- **Transformation** means having a focus on fostering innovative, transdisciplinary, culturally and linguistically responsive and impactful projects and programs to improve the health of OHA priority populations.

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). CCOs' work of building their equity infrastructure using their health equity plans allows them to have **equity foundations**. Those foundations are necessary to identify inequities and disparities and **take responsibility, create systems, and implement policies and processes** for addressing them using an equity-centered approach, because they have explicitly prioritized **equity as a key component of their organization mission and goals.** If your CCOs is using items from your health equity plan in your TQS, your TQS must demonstrate how the project is transformative, inclusive and equitable. CCOs must explain very clearly how TQS health equity projects are transformative, inclusive and equitable.

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 culturally and linguistically, 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:

- Clearly identify and describe where and how the project addresses quality and/or transformation (see definitions above).
- Clearly identify goals that are inclusive and equitable.
- Demonstrate knowledge and consideration of state and federal laws regarding communication and accessibility in the design and implementation.
- Clearly describe how the project will improve and/or transform the services, assistance and support members receive in accessing and navigating the health care delivery system, community and social support services and statewide resources.

The following are relevant references that need to be considered when designing projects 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 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.

[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

- 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:

- Develop improvement strategies for current 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 and improve quality interpretive services available to members.
- Develop innovative processes and service improvement strategies to ensure subcontractors such as non-emergent medical transportation (NEMT) can field calls in other languages and can accommodate callers with disabilities.
- Develop processes to measure the effectiveness of CCO education and training efforts using learner outcomes (pre/post test scores, course completion rates) and process measures (hours of training completed, trainer satisfaction and participant engagement). It's important to use a mix of both types of metrics to get a well-rounded view of a training's effectiveness.
- Develop systems and processes to ensure behavioral and oral health services are culturally and linguistically appropriate.

Considerations in developing projects:

- Does the project clearly address quality improvement or transformation work for advancing health equity?
- Does the project align with the OHA health equity definition? (If not, explain why.)
- Does the project clearly explain how the activities support the OHA health equity definition?
- Has your CCO used an equity framework 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 framework has been applied. If not, why not?)

4. 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. The goal of an oral health integration project should be to enhance access to oral health services by integrating oral health into primary and behavioral health care, as well as promoting the role of the dental office as a part of whole-person care.

TQS projects for this component must:

- Allow 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; **and**
- Allow members to access oral health care outside of the traditional dental office; **and**
- 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.

5. PCPCH: Member Enrollment

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

If your CCO earned a weighted PCPCH enrollment score of at least 85% in 2022 (as reported to and validated by OHA for 2022), your CCO is not required to submit a TQS project for PCPCH: Member Enrollment in 2024. In this case, your CCO would automatically earn the full score for this component without submitting a project.

The PCPCH weighted score formula = (# of members in Tier 1 clinics *1) + (# of members in Tier 2 clinics*2) + (number of members in Tier 3 clinics*3) + (# members in Tier 4 clinics*4) + (# members in 5 STAR clinics*5) / (total # of CCO members*5).

The REALD & GI requirement in TQS applies to any CCO member-level data used in projects. If your CCO uses individual criteria to assign members to a PCPCH, your TQS project for this component needs to use REALD & GI (and have a plan for using sexual orientation data).

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 that includes identifying and contracting with PCPCHs in your service area that are not in your network
- Strategy to increase the number of PCPCHs in your network by providing technical assistance to non-PCPCH primary care practices in your network to apply for PCPCH recognition. Technical assistance could include individual technical assistance, learning collaboratives (in-person or virtual) and/or educational webinars.

6. PCPCH: Tier Advancement

TQS projects for this component must have a 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 in Oregon's PCPCH recognition standards.

The REALD & GI requirement in TQS applies to any CCO member-level data used in projects. If your CCO uses member-level data to prioritize or plan tier advancement supports for clinics, your TQS project for this component needs to use REALD & GI (and have a plan for using sexual orientation data).

Project examples:

- Learning collaboratives (in-person or virtual) or individual technical assistance for Tier 4 PCPCHs applying for Tier 5 PCPCH recognition.
- Learning collaboratives (in-person or virtual) or individual technical assistance to PCPCHs applying for a higher PCPCH tier level.
- Target one or two practices and work with them to apply for Tier 5 PCPCH recognition. Practices that are reluctant to apply for Tier 5 may be more likely to apply if they have coaching and support.
- Value-based payment arrangements with PCPCHs that encourage and support higher tier level attainment.

7. 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, even if this population overlaps with other designations such as civil commitment, aid and assist, and the psychiatric security review board. 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 improve 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:

- 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 through 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 9a).
- 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, Pt 3, Sec h).
- 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 9a(3) 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.

Special Health Care Needs (SHCN)

In the SHCN components, your CCO shall **identify a population** within your special health care needs population and focus on evidence-based strategies or actions to improve health outcomes and/or improve care management of the selected population's health condition(s). You can use a number of data sources to identify areas where poor outcomes, lack of member engagement, lack of regular health care appointments, lack of discharge education, or other multiple risk factors contribute to poor health outcomes for your targeted population.

Quality improvement should focus on evidence-based approaches that create structured **strategies to improve your target population's health**. Your CCO can use any number of innovative approaches, such as increasing focus within care coordination, improving data sharing with partners engaged in member care, increasing member engagement or outreach with traditional health workers, building member self-management skills for their disease, medication management or monitoring, or engaging specific chronic care strategies in care plan development and monitoring. Use the narrative to describe your model and approach to improve your SCHN population's health, and use the activities and monitoring measures to clearly demonstrate the steps you will take to get to those outcomes and how progress will be measured.

Projects must **measure health variables that are relevant to showcasing improvements**. Projects that do not focus on identifying and measuring short- and long-term monitoring activities related to member health improvements will not meet this component's requirement. See the examples table below for types of measurable activities necessary for a successful SHCN quality improvement project. OHA expects clearly written measurable (SMART/SMARTIE) short- and long-term monitoring activities that include identified health variable tracking.

The SHCN components refer to your CCO's assessment and analysis of the quality, impact 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 and focus on reducing unnecessary readmissions and improving outcomes; and
- Track health variables that can demonstrate the effectiveness of your quality improvement project over time. Select meaningful variables that are linked to documenting health improvements for the selected population based on the unique needs and issues identified.

SHCN population definition (applies to both SHCN components):

"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, 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), or 3) are a member of the prioritized populations as defined in OAR 410-141-3870. 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.

Consider aligning your project with CCO metrics goals, such as targeting increasing behavioral health screenings for members in long-term care settings or reducing hospital readmissions for members with SPMI or chronic conditions. Your CCO could also look for when a SHCN population has outliers for certain CCO metrics; for example, interventions to improve chronic disease management, such as for children with asthma, to reduce avoidable emergency room. A key to selecting your project and health improvement targets is to understand the data for your members with special health care needs. The narrative should link closely to the selected monitoring activities to form a cohesive QI project.

Every CCO is required to submit two SHCN projects, focusing on the following populations:

- **Full benefit dual eligible population**
- **Non-duals Medicaid population**

The following are relevant references for SHCN TQS components:

- 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 CCO members with special health care needs. 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 2g (Providers and Delivery System: Access to Care) and Ex B, Pt 9a (Delivery System Dependencies: Intensive Care Coordination for Prioritized Populations and Members with Special Health Care Needs).
- 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 2g 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 in priority populations (OAR 410-141-3860 and OAR 410-141-3870).
- CCO-LTSS MOU requirements to address elements related to CCO populations with complex care needs on collaborative care planning, care transitions and other elements as detailed in guidance and tracking materials: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-LTSS.aspx.

Examples of short- and long-term health monitoring measures		
Note: Track all member-level measure data by REALD & GI categories		
Health topic	**Short-term health monitoring measures**	**Long-term heath outcome measures**
Diabetes	A1C testing/monitoring; diabetic medication refills; participation in diabetes self-management programs; regular primary care visits	Hemoglobin A1C control; avoidable emergency department visits
Mental illness	Discharge planning documents are being shared with all providers; referral and follow-up to appointments to manage chronic conditions; medication refills; regular behavioral health providers visits or documented peer services	Emergency department visits among members with mental illness; hospitalization rate among members with SPMI
Asthma	Primary care visits; medication refills and management; home visits for environmental trigger remediation	Hospital admissions; readmissions, avoidable ED visits
Dementia	Depression screening by primary care providers for members with dementia diagnosis; health information exchange workflow for dementia care coordination and planning; integrated care plans; medication reconciliation	Unnecessary emergency department admission for members with dementia
Falls	Medication reconciliation and review, medication therapy management program participation; home visits for safety review/homes receiving safety modifications like new exterior stair railings	Fall rate, hospitalizations for falls

	or ramps; participation in/ completion of falls prevention programs	

8. SHCN: Full benefit dual eligible (FBDE) population

Note: See overall SHCN guidance above, which applies to both SHCN components.

TQS SHCN projects should clearly identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how the CCO expects members with special health care needs (see SHCN population definition above) will benefit and see improvement from the project. **TQS projects for the SHCN components must document improvement in health status.** Projects that track health care services utilization or social determinants of health without clearly linking to health care improvements and outcomes for a targeted population do not meet the current requirements for SHCN projects. This project must be focused on the CCO's full benefit dual eligible members with special health care needs for an issue(s) identified by the CCO and aligned Medicare Advantage (MA) plan(s). While a CCO can identify a target population larger than those in the aligned MA plan, the project must demonstrate clear collaboration with the aligned MA plan in ways that are within expectations for care coordination within CCO contractual affiliation expectations.

CMS strongly supports increased integrated care for FBDE members in CCOs and their affiliated/contracted MA plan or MA dual special needs plan (DSNP). DSNPs have been 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. All CCOs are required to focus a TQS project on dual-eligible members with special health care needs.

- **If your CCO has a DSNP contract**, contact your DSNP quality team to collaborate on your duals project and submit your 2024 DSNP project with your TQS submission as the required duals project focused on FBDE members with SHCN. This project will be reviewed and scored as a CCO TQS project and meet the DSNP COBA requirement.
- **If your CCO doesn't have a DSNP contract**, your CCO is still required to develop a special health care needs project for FBDE members. OHA strongly encourages partnership with affiliated/contracted MA plans and/or the members' Medicare providers, since it is difficult to achieve quality improvement for dual eligible members without alignment.

TQS projects for this component must:

- **Identify a population within your FBDE members with SHCN**, as defined above, for which you are seeking to improve health outcomes.
- **Utilize evidence-based or innovative strategies** to ensure your identified population has access to integrated and coordinated care (appropriate care, care coordination, treatment plan, care transition processes and appropriate follow-up). Is there evidence that this type of intervention will be effective to achieve your targeted health improvement outcome? What innovations are driving

your project? (For example, sending a brochure about diabetes would not be an innovative approach.)

- **Primarily focus on quality improvements related to improving health outcomes** for your identified SHCN population. These activities should have a clearly demonstrated ability to make an impact on health of your identified SCHN population. Ensure project narrative and activities clearly describe how they will achieve targeted health improvement. Ensure you have selected appropriate health variables to showcase targeted short- and long-range health improvements.
- **Identify and monitor health outcomes for your identified SHCN population. Include both short-term and long-term health monitoring.** See table of examples above. If the project only addresses underlying social factors, member surveys or access to services and not health outcomes, it will not meet this TQS component requirement. Ensure all monitoring activities are written with clearly defined and measurable objectives that can demonstrate progress toward targeted health improvements.
    - Include process measures to showcase how you are monitoring your team's work to ensure targets are achieved — such as tracking referrals, appointments attended, THW home visits, medication refills, completion of screenings or annual medical testing — which ultimately help ensure health improvements are able to be achieved.
    - Include health outcome measures, such as reductions in unnecessary ER visits, hospitalizations or readmissions, or improvements in core health variables in people with chronic conditions or disabilities. Health outcome measures are the core of a successful project design.
- **Include clear collaboration with your affiliated MA plan** in the project design, data sharing, monitoring and/or implementation and outcome measurements.

Questions to consider in developing projects:

- Does the project clearly connect the identified SHCN population and the project's rationale by showcasing evidence-based documented information that supports specific health outcome improvements targeted by the project? (Why will this project improve member health?)
- Does the project show how the project methodology expects to achieve health improvements through the chosen monitoring activities and metrics tracking? (That is, what do we know about the current state, what do we want to be the future state, and how will we get there?)
- What short- and long-term health data/metrics are you tracking to demonstrate health improvement for your project's targeted population?
- 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? Has your project clearly described the relationship of your MA plan and CCO in the narrative?
- What short-term and long-term measurable monitoring activities might be incorporated? Are monitoring activities written so they are clear and easy to measure, and show improvement? TQS projects should identify the key variables that document (1) the improvement project is being implemented as designed and (2) those variables that showcase health improvement. Some examples of monitoring activities:

    - Short term: Are we tracking referrals, follow-up on scheduled appointments after a transition, that discharge planning documents are being shared with all providers; utilization of preventive or wellness services; tracking attendance at provider appointments to manage chronic conditions; ensuring review of medications where necessary to identify any high-risk medications or ensuring prescriptions are being filled regularly?
    - Long term: Are we tracking metrics like reducing readmissions or avoidable emergency department utilization; disparity measure for emergency department utilization among members with mental illness; tracking improvements in PQI 05: COPD or asthma in older adults admission rate; PQI 08: congestive heart failure admission rate; PQI 15: asthma in younger adults admission rate; impacting specific health care measures like reducing A1Cs, reduction in falls percentage in population, etc.? What Medicare metrics could we also be monitoring?
- 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 into the project?
- How does the project align with specific health information exchange, 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, 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 of health that might be impacting unique populations like those with disabilities, issues in congregate care settings including populations in LTSS programs, or recently discharged to home after a skilled nursing facility stay?
- How are you taking a deeper dive on disparities in underserved minority populations (like seniors for whom English is not their 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.

9. SHCN: Non-duals Medicaid population

Note: See overall SHCN guidance above, which applies to both SHCN components.

TQS SHCN projects should clearly identify the target population and align the rationale, improvement objectives and monitoring activities to demonstrate how the CCO expects members with special health care needs (see SHCN population definition above) will benefit and see health improvement from the project. Review the SHCN definition above to ensure your project aligns with expectations and will meet requirements for a SCHN project. **TQS projects for the SHCN components must document improvement in health status.** Projects that track health care services utilization or social determinants of health without clearly linking to health care improvements and outcomes for a targeted population do not meet the current requirements for SHCN projects.

TQS projects for this component must:

- **Identify a population within your non-FBDE Medicaid members with SHCN**, as defined above, for which you are seeking to improve health outcomes.
- **Utilize evidence-based or innovative strategies** to ensure your identified population has access to integrated and coordinated care (appropriate care, care coordination, treatment plan, care transition processes and appropriate follow-up). Is there evidence that this type of intervention will be effective to achieve your targeted health improvement outcome? What innovations are driving your project? (For example, sending a brochure about diabetes would not be an innovative approach.)
- **Primarily focus on quality improvements related to improving health outcomes** for your identified SHCN population. These activities should have a clearly demonstrated ability to make an impact on health of your identified SCHN population. Ensure project narrative and activities clearly describe how they will achieve targeted health improvement. Ensure you have selected appropriate health variables to showcase targeted short- and long-range health improvements.
- **Identify and monitor health outcomes for your identified SHCN population. Include both short-term and long-term health monitoring.** See table of examples above. If the project only addresses underlying social factors, member surveys or access to services and not health outcomes, it will not meet this TQS component requirement. Ensure all monitoring activities are written with clearly defined and measurable objectives that can demonstrate progress toward targeted health improvements.
    - Include process measures to showcase how you are monitoring your team's work to ensure targets are achieved — such as tracking referrals, appointments attended, THW home visits, medication refills, completion of screenings or annual medical testing — which ultimately help ensure health improvements are able to be achieved.
    - Include health outcome measures, such as reductions in unnecessary ER visits, hospitalizations or readmissions, or improvements in core health variables in people with chronic conditions or disabilities, are the core of a successful project design.

Questions to consider in developing projects:

- Does the project clearly connect the identified SHCN population and the project's rationale by showcasing evidence-based documented information that supports specific health outcome improvements targeted by the project? (Why will this project improve member health?)
- Does the project show how the project methodology expects to achieve health improvements through the chosen monitoring activities and metrics tracking? (That is, what do we know about the current state, what do we want to be the future state, and how will we get there?)
- What short- and long-term health data/metrics are you tracking to document health improvement for your project targeted population?
- What short-term and long-term measurable monitoring activities might be incorporated? Are monitoring activities written so they are clear and easy to measure, track and show improvement? TQS projects should identify the key variables that document (1) the improvement project is being implemented as designed and (2) those variables that showcase health improvement. Some examples of monitoring activities:
    - Short term: Are we tracking referrals, follow-up on scheduled appointments after a transition, and discharge planning documents are being shared with all providers; utilization of preventive or wellness services; tracking attendance at provider appointments to manage chronic conditions; ensuring review of medications where necessary to identify any high-risk medications or ensuring prescriptions are being filled regularly?
    - Long term: Are we tracking metrics like reducing readmissions or avoidable emergency department utilization; disparity measure for emergency department utilization among members with mental illness; tracking improvements in PQI 05: COPD or asthma in older adults admission rate; PQI 08: congestive heart failure admission rate; PQI 15: asthma in younger adults admission rate; impacting specific health care measures like reducing A1Cs, reduction in falls percentage in population, etc.?
- 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 into 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 prevention programs 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, 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, adult foster homes, or recently discharged to home after a hospital or behavioral health inpatient 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)?