OHA Review of 2024 CCO Transformation and Quality Strategy (TQS)
Cascade Health Alliance

Overview

Scoring process

OHA subject matter experts reviewed each project against the TQS guidance document for each component assigned to that project.

- Reviewers assigned a separate score of 0–3 for relevance, detail and feasibility.
- Relevance scores of zero mean the project did not meet the component-specific requirements; for these projects, detail and feasibility will automatically also score a zero.
- Relevance, detail and feasibility scores were summed for a total possible component score of 9.
- If a CCO submitted multiple projects for a component, scores were averaged to create a final component score.

How scores will be used

CCO scores will provide OHA with a snapshot of how well CCOs are doing in component areas. The scores will help OHA see what improvement is happening and identify areas of technical assistance needed across CCOs. Individual CCO scores and written assessments will be posted online.

How to use this feedback

CCOs should use this assessment to update quality improvement-related deliverables and projects to ensure quality for members, while also continuing to push health system transformation to reduce health disparities across the CCO's service area.

Background

As part of a CCO quality program, the TQS includes health system transformation activities along with quality activities to drive toward the triple aim: better health, better care and lower cost. CCOs will submit a plan (that is, a TQS project) to improve each TQS component area. The TQS highlights specific work a CCO plans to do in the coming year for the quality and transformation components. It is not a full catalog of the CCO's body of work addressing each component or full representation of the overall quality program a CCO should have in place.

Next steps

1. **Schedule a feedback call with OHA (optional)** – OHA is offering feedback calls to any CCOs wanting to participate. If your CCO hasn't done so already, please fill out the scheduling form at https://www.surveymonkey.com/r/NRRRLBP. During the call, OHA will answer questions about this assessment. Calls are available in September and October.
2. **If needed, upload a redacted version (with redaction log)** to the CCO Contract Deliverables Portal.

Notes:

- **Resubmissions** – OHA will not be accepting resubmissions. This helps ensure transparency across the original TQS submission and resulting written assessment. Feedback from the written assessment and feedback calls are intended to help CCOs focus on ways to improve projects and documentation in future submissions.
- **What will be posted** – OHA will post each CCO's entire TQS submission (including any attachments) — or redacted version, if approved by OHA — along with written assessment and scores.

CCO TQS assessment

Component scores

Average score	# of projects	Prior year score	Component
7	1	9	Behavioral Health Integration
9	1	3	CLAS Standards
9	1	6	Health Equity: Cultural Responsiveness
8	1	7	Oral Health Integration
9	1	8	Patient-Centered Primary Care Home: Member Enrollment
9	1	9	Patient-Centered Primary Care Home: Tier Advancement
7	1	8	Severe and Persistent Mental Illness
5	1	8	Special Health Care Needs – Full Benefit Dual Eligible
5	1	8	Special Health Care Needs – Non-dual Medicaid Population
68 (out of 81; 84%)		**98.5 (out of 117; 84.2%)**	**TOTAL TQS SCORE**

Note: Four components (Grievance and Appeals System, Health Equity: Data, Social Determinants of Health & Equity, and Utilization Review) were removed in 2024, which accounts for the difference in total points possible from 2023.

Project scores and feedback

Project ID# 59: SPMI and THW Sustainable Capacity

Component	Relevance score	Detail score	Feasibility score	Combined score
Behavioral health integration	2	3	2	**7**
Serious and persistent mental illness	3	2	2	**7**

OHA review (Behavioral health integration): The project does not adequately address the following relevance criteria:

> 4- Project demonstrates how the integration model makes the behavioral health system more equitable (that is, decreases health disparities and improves health outcomes).
>
> 5- Project utilizes the electronic health record/health information exchange system in the infrastructure to support the delivery of integrated care.
>
> 6- Project implements a care team structure that includes all disciplines involved in the member's behavioral health and primary care.
>
> 7- Project clearly explains strong collaboration and partnership with other regional health providers such as school-based health centers, substance use disorder providers, community mental health programs and primary care providers, and other community partners such as law enforcement.

There are noted efforts being made to engage with community-specific groups to provide culturally relevant interventions, and there is a concrete plan for REALD & SOGI data collection and analysis to enhance service delivery. There is room for improvement in the activities, targets, benchmarks, and data sources to ensure the project is feasible.

(Serious and persistent mental illness): This project is relevant and meaningful to the identified population. The connection with various committees, inclusive of Hispanic, Tribal, and students, is a great start. The project does well to include a role for THWs, which is critical to the project and strategy. The project needs additional activities and details to identify and refine solutions. For example, the project only identifies general population challenges without a review of cultural influences and solutions based on problem-solving with associated committees, REALD or SOGI. This makes refining the solutions very general and not in sync with various populations. The project includes reasonable, pragmatic measures with moderate and feasible goals, but there are only short-term goals without measuring the effect of the intervention.

Active care plans for the SPMI population are a standard per CCO contract (Exhibit B, 7G(2) Care Coordination, EBP, Individual Care Plans). A baseline of 25% should require a corrective action plan, not an increase to 50%, which was the same goal as the prior year's project.

OHA recommendations (Behavioral health integration): Clearly define the specific integration models being used. Provide more information about what behavioral, physical and oral health services the project is providing referrals for, in addition to the SDOH service connections. For the closed loop referral system noted, describe the data on the type of referrals made, how many members made and kept appointments, or followed through on the referrals. If the data is not available, describe the barriers to collecting the data. This would inform the work the THWs are doing and better show whether the community is being equitably served. This would also highlight barriers to obtaining services. As REALD & SOGI data continues to be collected, ensure there is member-level disaggregation for the monitoring metrics, targets, and benchmarks by REALD & GI categories.

(Serious and persistent mental illness): Review cultural influences and solutions based on problem-solving with associated committees and using REALD or SOGI data, and refining project activities to address needs. Include longer-term monitoring measures to track outcomes. Consider if there are other roles required to support the THWs' efforts for adequate engagement. The committees developed will be a great source for problem-solving this challenge. For example, community-based services may be preferred (or not preferred) depending on the population.

Project ID# 33: Cultural and Linguistic Services Provision

Component	Relevance score	Detail score	Feasibility score	Combined score
CLAS standards	3	3	3	**9**
Health equity: Cultural responsiveness	3	3	3	**9**

OHA review: The project meets all relevance criteria and provides a good explanation of progress to date. The project includes an appropriate level of background that aligns it with CLAS and uses REALD & SOGI data.

OHA recommendations: A dashboard is not considered a transformational tool. Consider better defining how the NCQA accreditation aligns with CLAS. While the TQS reviewer understood the relationship, others less familiar with NCQA and CLAS may not.

Project ID# 364: Medical Dental Integration				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Oral health integration	3	2	3	**8**

OHA review: The narrative provides a meaningful explanation for why the project was chosen and how activities will make an impact on the selected population. The project mentions that sexual orientation data will be used once available but does not provide a plan or timeline. Gender identity is missing from this year's analysis. Project activities are directly related to the TQS component, appear likely to make progress in addressing the gaps identified, and demonstrate meaningful CCO actions throughout the year.

OHA recommendations: Ensure the project addresses all REALD & SOGI requirements.

Project ID# 365: Comprehensive PCPCH Plan				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
PCPCH: Member enrollment	3	3	3	**9**
PCPCH: Tier advancement	3	3	3	**9**

OHA review (PCPCH: Member enrollment): The project details a comprehensive plan to increase member assignment to PCPCHs. CHA has done a fantastic job of detailing each component of its project plan, what hasn't worked, lessons learned, what went well, and the path forward. The project takes into consideration the staffing struggles PCPCHs have been experiencing as well as labor market shortages. The reviewer is especially appreciative of the detailed plan to enrich the CCO's analysis of PCPCH assignment based on REALD data, thus improving health equity. The project seems feasible as described.

(PCPCH: Tier advancement): The project outlines a detailed plan to assist PCPCH practices in achieving higher-tier recognition. The project seems feasible as described.

OHA recommendations: None.

Project ID# 368: Collaboration and Care Coordination for LTSS FBDE Population				
Component	**Relevance score**	**Detail score**	**Feasibility score**	**Combined score**
Special health care needs: Full benefit dual eligible	2	2	1	**5**

OHA review: The project met most relevance criteria, but is missing the following:

- Project clearly identifies and monitors health outcomes for your identified SHCN population. It includes both short-term and long-term health monitoring.

The overall work is commendable in making steps toward building the ability to better track outcomes, and there are efforts to build a more aligned process with DSNP for data sharing and care coordination. However, the project has yet to move beyond process monitoring activities and toward SMARTIE objectives that meet SHCN requirements.

The activities and monitoring metrics don't include tracking by REALD & SOGI to identify progress in addressing disparities. The project is not fully feasible due to a lack of measurable targets to make progress

toward goals, and potentially inadequate staff resources and coordination to ensure data tracking before the start of the project.

OHA recommendations: Include appropriate long- and short-term health outcome metrics that include SMART objectives (and consider SMARTIE objectives). For example, 3.1 could include measures to improve ED utilization and readmissions. Consider short-term metrics that cut across chronic diseases, such as medication refills for RSA, diabetes, depression, etc. to show improvements in health outcomes more clearly. Track monitoring metrics by REALD & SOGI data to identify any disparities in health outcomes. Consider whether the project is adequately staffed to be successful.

Project ID# 366: Holistic Diabetes Management

Component	Relevance score	Detail score	Feasibility score	Combined score
Special health care needs: Non-dual Medicaid population	2	1	2	**5**

OHA review: The project met most relevance criteria, but is missing the following:

- Project primarily focuses on quality improvements related to improving health outcomes for your identified SHCN population. It includes both short-term and long-term health monitoring.

The project is missing long-term health monitoring metrics. While the project uses race and ethnicity data in the narrative to inform the activities, it's missing use of language, disability and gender identity data. The project also doesn't adequately incorporate REALD & GI data into short-term health outcome metrics to support longer-range targets. Without tracking monitoring metrics by REALD & GI, the project's ability to identify and address disparities is at risk. The 2024 efforts to implement new workflows, educational materials, and training initiatives to address the CCO-identified REALD gaps may support improvements in REALD & GI data in the health outcome metrics.

The project is somewhat feasible as written; however, the improvement targets included are very low overall, which may reflect uncertainty in the improvement strategy. The project appropriately includes plans for stronger partnerships with providers to collaboratively address under-utilization/lack of current engagement and achieve outcomes.

OHA recommendations: Include long-term health monitoring metrics. For example, the narrative mentioned reduced ED utilization and hospitalization, but those aren't included as long-term metrics. Review activities to ensure they can impact the intended outcome and consider appropriate improvement targets. For example, add activities to show how the project will engage members who did not get A1C testing, or have lower ongoing A1C testing.

Include analysis of language, disability and gender identity to identify and address potential disparities. Track member-level health monitoring metrics by disaggregated REALD & GI categories.