**OHA Review of 2024 CCO Transformation and Quality Strategy (TQS)**
**Jackson Care Connect**

## 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 | 8 | Behavioral Health Integration |
| 9 | 1 | 9 | CLAS Standards |
| 9 | 1 | 9 | Health Equity: Cultural Responsiveness |
| 9 | 1 | 9 | Oral Health Integration |
| 9 | 1 | 9 | Patient-Centered Primary Care Home: Member Enrollment |
| 9 | 1 | 9 | Patient-Centered Primary Care Home: Tier Advancement |
| 9 | 1 | 7 | Severe and Persistent Mental Illness |
| 9 | 1 | 5 | Special Health Care Needs – Full Benefit Dual Eligible |
| 7 | 1 | 7 | Special Health Care Needs – Non-dual Medicaid Population |
| **77 (out of 81; 95.1%)** | | **105.3 (out of 117; 90%)** | **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# 511: Hospital Based SUD Navigator

| Component | Relevance score | Detail score | Feasibility score | Combined score |
|---|---|---|---|---|
| Behavioral health integration | 3 | 2 | 2 | **7** |

**OHA review**: Project includes detailed information on how SUD navigators provide continuum of care through prevention efforts. Strengths include sharing resource information with SUD navigators even though they are in different hospitals, and planning to review and analyze data to develop a quality improvement strategy. Will hospitals' internal system barriers cause issues for securing future funding?

**OHA recommendations**: More details are needed on why data collection for REALD and SOGI has been difficult and/or how regularly CCO will review data.

#### Project ID# 129: Supporting the Communication Needs for Members

| 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:** CCO focuses on community and member collaborations and partnerships. The addition of La Clinica and their role in this project makes this project transformational. Good data analysis.

Progress to date and lessons learned demonstrate great analysis of circumstances. CCO provides updates and justifications when targets were not met.

**OHA recommendations:** It's a little unclear why the project's population includes all JCC members. More detail in the rationale would be helpful.

| Project ID# 431: Oral Health Services in Primary Care | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| Oral health integration | 3 | 3 | 3 | **9** |

**OHA review**: Project addresses each of the three oral health integration component requirements. The narrative provides a meaningful explanation for why the project was chosen and how activities will make an impact on the selected population. Excellent level of detail and specificity. Goals for the project appear reasonable and realistic about what can be completed during the measurement period. Project activities are SMART (specific, measurable, achievable, relevant, and time-bound).

**OHA recommendations**: None.

| Project ID# 131: Patient-Centered Primary Care Home (PCPCH) Member Assignment | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| PCPCH: Member enrollment | 3 | 3 | 3 | **9** |

**OHA review**: Project fully addresses component definition and details a comprehensive plan to increase member assignment to PCPCHs. Plan includes activities to achieve benchmarks and targets. The project seems feasible as described.

**OHA recommendations**: None.

| Project ID# 379: Patient-Centered Primary Care Home (PCPCH) Tier Advancement | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| PCPCH: Tier advancement | 3 | 3 | 3 | **9** |

**OHA review**: The project outlines a detailed plan to assist PCPCH practices in achieving higher tier recognition. Clear path forward for how to improve processes to assist clinics increase tier levels. Activities are clearly outlined, with a good amount of context to support rationale. Activities, goals and targets are well thought out.

**OHA recommendations**: None.

| Project ID# NEW: Strategic Healthcare Investment for Transformation (SHIFT) | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| Serious and persistent mental illness | 3 | 3 | 3 | **9** |

**OHA review**: Project has a meaningful, relevant focus and identifies many potential areas for improvement. Use of this SHIFT model is a good, comprehensive approach to system improvement. Program implementation through initial assessments seems to be a good, measurable start. Measuring REALD and SOGI elements compared to the general population will be a beginning of better serving this population.

Both bipolar and schizophrenia seem over-represented in both ED and acute care hospitalizations, though it's not clear where this is being addressed.

**OHA recommendations**: Add activities that could address outcomes, such as reduction of ED and/or acute care hospitalization, to better measure outcomes of the SHIFT model. Consider opportunities to specifically address disparity for members with bipolar and schizophrenia.

| **Project ID# NEW: Vulnerability Framework and Rapid Access Care Planning** | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| Special health care needs: Full benefit dual eligible | 3 | 3 | 3 | **9** |

**OHA review**: Project uses innovative approach for risk assessment combining clinical risk, social risk, access and coordination risk into an algorithm for understanding unique vulnerabilities of SHCN duals population. Project meets SHCN goals by incorporating short- and long-term health monitoring (as well as some care team process metrics) and collaborating with the DSNP plan. Project includes REALD analysis to work toward improving health disparities in vulnerable populations.

The project could benefit from additional detail within Activity 2 around specific health outcomes CCO is monitoring to show health improvement (see recommendations below).

Project is feasible, and it's laudable that that CCO is investing in additional data analysis resources to use more data to drive care teamwork. Timing to align with 1115 waiver SDOH resources and health equity goals noted.

**OHA recommendations**: Remember the importance for SHCN projects to show health improvement for members. Consider breaking down activities into tracking for specific activities to better understand effectiveness of intervention steps to get to longer-range outcomes. Consider measuring development of member-centric care plans as a short-term goal to better focus target on members (current metric for care coordination outreach is a process metric). Also consider tracking numbers of SDOH services received, and some of the other short-term medical goals outlined in the model presented. Better explain what AIC referral means.

| **Project ID# 446: Post Acute Residential Treatment** | | | | |
|---|---|---|---|---|
| **Component** | **Relevance score** | **Detail score** | **Feasibility score** | **Combined score** |
| Special health care needs: Non-dual Medicaid population | 3 | 2 | 2 | **7** |

**OHA review**: Community partnerships for this project showcase time and effort to build a unique model to address a very high-needs population and health issue. Strong partnership work, with an innovative solution. Great potential for impacting vulnerable population.

Some of the ongoing issues this project has with member engagement and low enrollment are predictable given the very specific selection of population. The number of targeted members for this project is extremely small to complete a quality improvement project/data analysis.

Project includes a limited number of health monitoring activities. As feedback from OHA last year called out, project is still missing a monitoring activity to track longer-range goals such as hospitalizations, ED use or completion of SUD treatment.

**OHA recommendations**: Add monitoring measure(s) for longer-range health outcomes. Track member-level monitoring activities by REALD/SOGI to monitor for disparities (even though CCO hasn't found disparities in engagement).

Consider tools such as motivational interviewing to gauge readiness/stages of change to see if those not remaining or engaging are perhaps not in stages of readiness (patient activation measure). Team can then target messaging based on readiness. Consider whether using additional peers to maintain direct support of members in IVAB treatment increases completion rates.

With such low enrollment, consider whether tracking SUD treatment/drug use for those outside of the narrow project population would be an option. CCO could look at intermediate and long-range measures. How much is the rest of SUD population presenting with smoking drug use over IV drug use monitored to ensure connection to treatment and follow-up for things like medication refills, SUD treatment/engagement/completion, medication-assisted treatment, reduction of ED or hospitalizations?