The Carolinas Center *for* Medical Excellence

2021 Annual Summary Report for Performance Improvement Projects

May 9, 2022

Our Mission

We help people by improving the quality of health care.

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I. Introduction

This Annual Summary Report for Performance Improvement Projects (PIPs) is submitted to North Carolina Medicaid as demonstration of the completion of requirements outlined in *Task 4: Validation of Prepaid Inpatient Health Plan (PIHP) Performance Improvement Projects (PIPs)* of the External Quality Review (EQR) contract between The Carolinas Center for Medical Excellence (CCME) and North Carolina Medicaid. This report summarizes the validation of PIPs for six PIHPs that have participated in External Quality Reviews (EQRs) during 2020-2021. The six PIHPs included in this report are Alliance Health (Alliance), Eastpointe, Sandhills Center (Sandhills), Partners Health Management (Partners), Trillium Health Resources (Trillium), and Vaya Health (Vaya). The report concludes with a summary of strengths and opportunities generalized for all PIHPs. Cardinal Innovations Healthcare's (Cardinal) catchment area was dispersed across other North Carolina PIHPs in 2021. This disbursement was completed and Cardinal closed in January of 2022. Therefore, no Cardinal data is presented in this report.

II. Overview

PIHPs are responsible for designing, conducting, and reporting PIPs. The use of sound methodology helps each project achieve improvements in care and services. Federal regulation, through the EQR protocol, requires states to validate any projects in the last 12 months and assess core project design elements.

III. Technical Methods of Data Collection

CCME's statistical, clinical, and behavioral health experts use a 9-step methodology, consistent with the Centers for Medicare & Medicaid Services (CMS) protocol, as well as the *National Committee for Quality Assurance (NCQA) Guidebook, Health Care Quality Improvement Studies in Managed Care Settings - Design and Assessment: A Guide for State Medicaid Agencies, (Washington, DC: 1994)*. This methodology, presented in *Table 1, CCME PIP Validation Steps*, is used to execute the NC Medicaid-required assessment and evaluation activities in the CMS protocol.

Table 1. CCME PIP Validation Steps

Step	Description	Important Question
Assessment of the Methodology for Conducting Projects		
1	Review the selected study topic(s)	How did the plan select the project topic and why is the project important?
2	Review the PIP Aim Statement	Is the project based on a clear and concise set of aims?

Step	Description	Important Question
3	Review the identified study population	Is the plan utilizing relevant populations and key aspects of enrollee care?
4	Review sampling methods	Is the plan using appropriate sampling methodology and techniques?
Evaluation of Project Validity and Reliability		
5	Review Selected PIP Variables and Performance Measures	Did the study use objective, clearly defined, measurable indicators?
6	Review Data Collection Procedures	Are appropriate data collection processes used by the plan for this project?
7	Review Data Analysis and Interpretation of Study Results	Did the plan analyze and interpret the data collected from the project using correct procedures?
8	Assess Improvement Strategies	Are the interventions identified and implemented by the plan reasonable for the project? Did the plan analyze and interpret the data collected from the project using correct procedures?
9	Assess the Likelihood that Significant and Sustained Improvement Occurred	Is any improvement claimed by the plan a valid improvement in care? Has the plan sustained any improvement gained in the past?

During the validation, each project's interventions and outcomes are reviewed and summarized. The EQR Team scores each PIHP's projects based on the overall validity and reliability of the PIP results using a validation worksheet. Validation worksheets include all the requirements outlined in the *CMS EQR Protocol 1: Validation of Performance Improvement Projects*, dated October 2019.

IV. Comparative Findings

A. Overall Validation Status

For the 2021 PIP validation review year, CCME validated 28 projects across the six PIHPs. Table 2 provides an overview of the **overall** validation review score each PIHP received.

Table 2. Overall Validation Score for Each PIHP

PIHP	Overall Validation for PIPs
Alliance	Met
Eastpointe	Met
Partners	Met
Sandhills	Met
Trillium	Met
Vaya	Met

Met = All of the PIHP's PIPs received validation scores of 90% or higher

Partially Met = At least one of the PIHP's PIP validation score was above 60% or one PIP validation score was below 90%

Not Met = All of the PIHP's PIPs received validation scores of 60% or lower

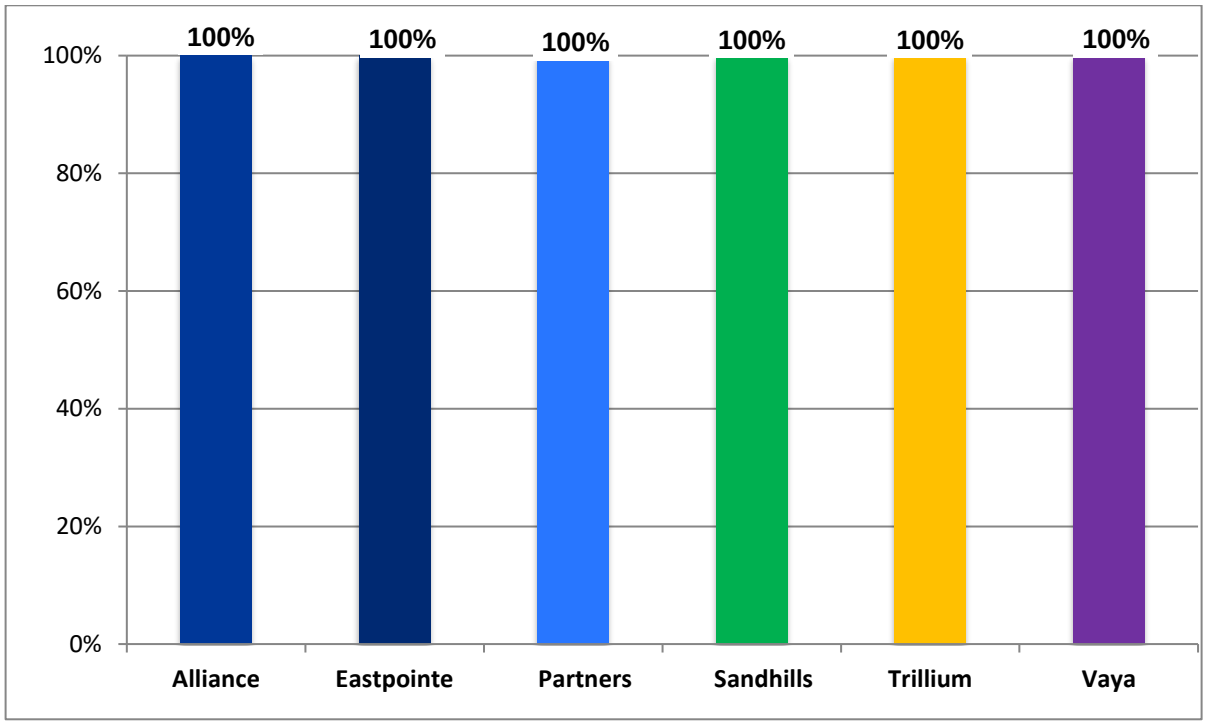
The validation decision categories for each PIP submitted, as well as the total number of PIPs validated for each PIHP are shown in Table 3.

Table 3. Validation Decision Categories

PIHP	High Confidence	Confidence	Low Confidence	Not Credible	Total # of PIPs Validated
Alliance	6	-	-	-	6
Eastpointe	4	-	-	-	4
Partners	5	-	-	-	5
Sandhills	4	-	-	-	4
Trillium	5	-	-	-	5
Vaya	4	-	-	-	4

The percentage of PIPs receiving "High Confidence" validation decisions for each PIHP is displayed in Figure 1. All six PIHPs had all PIPs scored in the "High Confidence" range.

Figure1. PIPs in High Confidence Validation Decision Category by PIHP



B. Individual PIP Topics and Scores per PIHP

All PIHPs received "High Confidence" validation decisions for all submitted PIPs. A summary of validation scores for each PIP and validation decision category status are presented in Table 4.

Table 4. Individual PIP Validation Score and Decision Categories

PROJECT	VALIDATION SCORE	VALIDATION DECISION
ALLIANCE		
7 DAY DHB SUD*	73/74 = 99%	High Confidence in Reported Results
7 Day DMH MH*	79/79 = 100%	High Confidence in Reported Results
7 Day DMH SUD*	79/79 = 100%	High Confidence in Reported Results
APM*	79/79 = 100%	High Confidence in Reported Results
SSD*	79/79 = 100%	High Confidence in Reported Results
TCLI PCP Visits*	73/74 = 99%	High Confidence in Reported Results
EASTPOINTE		
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%*	73/74 = 99%	High Confidence in Reported Results
Decrease Emergency Department (ED) admissions for Active Members to 20%*	79/79 = 100%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)*	76/79 = 96%	High Confidence in Reported Results
Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually	74/74 = 100%	High Confidence in Reported Results
PARTNERS		
Opioid Engagement*	79/79=100%	High Confidence in Reported Results
SUD Initiation and Engagement*	79/79=100%	High Confidence in Reported Results
Registry of Unmet Needs Services*	73/74=99%	High Confidence in Reported Results
Initial NC TOPPS Interviews	73/74=99%	High Confidence in Reported Results
TCL Housing Loss Reduction	73/74=99%	High Confidence in Reported Results
SANDHILLS		
Assure Consistent Connection to Community Services*	79/80 = 99%	High Confidence in Reported Results
NC-TOPPS Interview Data Accuracy	74/79 = 94%	High Confidence in Reported Results

PROJECT	VALIDATION SCORE	VALIDATION DECISION
Routine Appointments kept*	73/74 = 99%	High Confidence in Reported Results
TCLI Timeliness Documentation Submission	67/72 = 93%	High Confidence in Reported Results
TRILLIUM		
Super Measure MH*	78/79 = 100%	High Confidence in Reported Results
Super Measure SU*	73/74 = 99%	High Confidence in Reported Results
Utilization of ED*	78/79 = 99%	High Confidence in Reported Results
MST Utilization*	79/79 = 100%	High Confidence in Reported Results
TCLI 90 Day Contact	79/79 = 100%	High Confidence in Reported Results
VAYA		
TCLI PN Housing Usage	73/74=99%	High Confidence in Reported Results
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days*	79/79=100%	High Confidence in Reported Results
Community Crisis Management*	72/72=99%	High Confidence in Reported Results
ADATC VIP*	84/84=100%	High Confidence in Reported Results

**Indicates clinically focused PIP*

V. PIP Status and Interventions

A summary of the status for each PIP and the active interventions are discussed in this section.

A. Alliance

Of the six PIPs, four showed improvement in outcomes and two PIPs showed a decline in the outcomes. The two PIPs that received a recommendation were the 7-Day DHB SUD PIP and the TCLI PCP Visits PIP.

Projects	Status	Interventions
7 DAY DHB SUD	Rate declined from 34% in April 2021 to 31% in May 2021. Goal is 40%.	Streamlining Processes – Collaborative adjustments of the efforts from various teams to create process efficiency, Peer Bridger Program – Rapidly connect members to care by directly referring them to peers, follow up phone calls
7 Day DMH MH	Rate was 29% in May 2021 and in June 2021 it was 35%. The goal is 40%.	Provider scorecard review, Streamlining Processes – Collaborative adjustments of the efforts from various teams to create process efficiency, follow up phone calls
7 Day DMH SUD	Rate was 28% in May 2021 and improved to 38% in June 2021. The goal rate is 40%.	Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review
APM	Rate improved from 31% in July 2021 to 33% in August 2021. The goal is 38%.	HealthCrowd campaign for awareness, Point of Care testing, Provider scorecards, staff education, provider data reports
SSD	Rate was 72% in July 2021 and improved to 75% in August 2021.	HealthCrowd campaign for awareness, Point of Care testing, staff education, data sharing
TCLI PCP Visits	Rate was 84% in October 2021 and declined to 78% in November 2021. The goal is 80%.	PCP visit tracking, staff education, provider communication programs

B. Eastpointe

A total of four PIPs were submitted. Two showed improvement and two PIPs had a decline in rates, including the SSD PIP and the Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days PIP.

Projects	Status	Interventions
Increase the Percent of Individuals Who Receive a 2nd Service Within or Less Than (≤) 14 Days to 35%	Rate most recently decreased slightly from 28.5% in Q1 t0 25.1% in Q2 for FY 2021. The goal is 35%.	Education to Provider Network (staff at front desk who make appointments) on Initiation of Services; Technical assistance call with walk-in clinics regarding peer support being utilized to increase follow-up rates; Collaborate with state/local hospitals regarding scheduling follow up appointments; Identify transportation resources/Chief of QM reached out to local DSS to inquire about transportation resources.
Decrease Emergency Department (ED) admissions for Active Members to 20%-Clinical	The rate reduced from 36% to 30% (improvement as lower rate is better). Goal is 20%.	MH/SU Care Specialist call ED daily; Hospital Transition team are assigned to local hospitals to assist with discharge planning; Clinical Operations to hold interdepartmental meeting to address ED re-admissions concerns; Development of Provider Self-Audit Tool and Workflow; Data review and technical assistance calls with ACTT Providers.
Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)	The 2019 rate for SSD was 66.4% and 202 was 65.5%. Goal is 80%. The SMD rate in 2019 was 36% and in 2020 it was 37%, so the SMD rate improvement (Goal is 70%).	Provider Enrichment Forum led by Medical Director and Associate Medical Director, Associate Medical Director presented at May Provider Meeting on the importance of including Diabetes screening/monitoring as a goal on the member's Person-Centered Plan (PCP).
Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually - Non Clinical	Rate has remained unchanged from FY2020 to FY2021 at 20%. This is at the goal rate.	One-on-one psychoeducation with natural supports, Provide motivational interviewing to TCLI members offering linkage to other supportive services and arranging trainings, monthly Meeting with TMS providers, Quarterly Meeting with IPS/SE, CST, and ACTT providers, Use of My Strengths app with members, ADANC Community Inclusion provider assists with decreasing separations, New CST service definition increases the clinical efficacy of the service, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, housing inspection forms presented to providers to assist members in identified areas.

C. Sandhills

A total of four PIPs were submitted for Sandhills. Of those four, two showed a decline in the outcome rate, one showed improvement in the outcome, and one PIP had baseline data only and improvement could not be assessed as of the EQR.

Projects	Status	Interventions
Assure Consistent Connection to Community Services - Clinical	Rate declined from 65% to 55% for percentage of providers connecting members to community services.	Make referrals to Care Coordination to facilitate referrals to follow-up services when appropriate; Continue technical assistance to providers with emphasis on follow up to community services
TCLI Timeliness of Documentation Submission- Non-Clinical	Rate for baseline is 8.13%. Goal is 0%. Baseline only reported.	TCL staff are encouraged to complete and submit documentation immediately after each contact; When documentation isn't entered, it is recommended that staff complete and submit all documentation the morning of the following day; Staff are encouraged to not respond to calls or emails or schedule meetings until all notes have been entered
NC-TOPPS Interview Data Accuracy- Non-Clinical	Rate improved from 78% to 82% for percentage of non-errors.	NCTOPPS training Presentation
Routine Appointments kept- Non-Clinical	Rate decreased from 35% to 21%. Goal rate is 66%.	Continue sending reminder texts and reminder calls; Talk with a specific walk-in clinic provider to resume participation in the slot scheduler to allow for appointments to be scheduled in that area; Research how to improve appointments kept for consumers being released from prison

D. Trillium

Five PIPs were validated for Trillium. Four of the five PIPs showed improvement in at least one outcome, with only one PIP showing decline in all outcomes (Super Measure SU).

Projects	Status	Interventions
MST Utilization	Rate improved from 9.09% to 12.57% with a goal of 14.7%.	Educating schools on MST services, DSS training, family education from care coordinators
Super Measure MH	DHB rate declined from 43.6% to 41.4% and is below the Trillium goal rate of 45%. The DMH rate improved from 20.0% to 22.7% although it below the goal rate of 45%.	Claims data review and assessment, data unit reports weekly, denials alignment in files, communication between contract managers and designated provider caseloads, provider education, Rapid Response Team
Super Measure SU	For DHB, the follow up rate declined from 50.3% to 48.6% and for DMH the rate decline from 41.7% to 29.5% for the most recent local data findings.	Health Connex ADT report, Opioid Treatment Centers, Rapid Response Team, provider education
ED Utilization	For measure #1 rate decreased from .54 to .65 but is still below the goal; measure #2 decreased from 76.95% to 75.59% which does not support improvement as the goal is 80%; measure #3 declined from 6.39 to 6.13 which is improvement and remains below the goal of 7.79%.	Wellness Recovery Homes, SUD Host Homes, ACCT Plus Pilot, BHUCs, Power BI Dashboard reporting
TCLI 90-Day Contact	Goal is 98%. Rate improved from 93.66% to 98.98%. It is above the goal in October 2021.	Early report runs in Incedo, weekly report to RI, discrepancy data review, status checks on in-reach members for eligibility

E. Partners

Five PIPs were submitted for validation. Two PIPs showed improvement in outcomes, and three PIPs had a reported decline, including Registry of Unmet Needs Services, Initial NC TOPPS Interviews, and TCL Housing Loss Reduction PIPs.

Projects	Status	Interventions
Opioid Engagement	The Medicaid rate improved from 66% to 82.6% with a goal of 62%. The non-Medicaid Rate improved from 63% to 74% with a goal of 57.8%. Both rates improved and are above the goal rates.	Transportation program, value-based contracting, provider training, member incentives, peer support services, office based Opioid Treatment centers, provider brainstorming meetings
SUD Initiation and Engagement	The rate improved from 30.2% to 42.5%.	Value-based contracts, provider training, housing initiative, provider specific data-reporting, recovery support services.
Registry of Unmet Needs Services	The percentage declined from 46% to 43% at the latest remeasurement. The goal is 55%.	Long term community supports, community living and supports, day supports, in-home skills building
Initial NC TOPPS Interviews	The percentage declined from 50% to 25% for Medicaid and 67% to 38% for IPRS/State. The goal is 80%.	Provider scorecards, provider meetings, webinars, distribution list
TCL Housing Loss Reduction	The number who lost housing increased in the most recent remeasurement. The % rehoused reduced from 25% to 11%.	Monthly visits, service provider discussions, lack of resource identification, communication, and outreach with members

F. Vaya

Vaya submitted four PIPs for validation. There were three PIPs that showed improvement in outcomes, and one that showed a decline in outcomes (TCLI PN Housing Usage).

Project(s)	Status	Interventions
TCLI PN Housing Usage- Non Clinical	The number housed in April was 6, and May was 6 (Goal is 10). Vacancy alerts declined from 10 to 3; alerts utilized declined from 4 to 1. Goal is 4. The housing rate remained unchanged although alert and utilization of alerts have declined.	Real time inventory access, communication between department managers, Standard Operating Procedures (SOP) document
Increase Rate of Routine Access to Care Calls Receiving Service Within 14 Days- Clinical	Rate for prison population improved from 35.5% to 37.8%; rate for other population improved from 71% to 88.4%. Both are above the goal rate of 50%.	iPads for real time information on members, contact information of probation officers shared with Vaya managers, workflow/process documentation, text message reminders for appointments, mental health specialized probation officers
Community Crisis Management – Clinical	MH Rate admissions increased from 1.37 to 1.56 (goal is 1.41; lower is better); SUD Rate declined from .39 to .27 for April and May, which is improvement. ED Admissions rate data were reported for Jan and Feb 2021 and increased to 1.73 (goal is 1.41 and lower rate is better).	Provider incentives and penalties, text message reminders, community planning for high-utilizers, interdisciplinary clinical reviews
ADATC VIP- Clinical	All SUD was sustained at 73% for the most recently reported 2 months; ADATC Follow-up was at 80% for the most recently reported 2 months (February and March 2021); ADATC Opt-In rate was sustained at 90% for the most recently reported 2 months (Feb and March 2021). All rates are above the goal rates of 40%.	Onsite/in-person care management, phone appointments for members, video conferencing with Complex Care Management, monthly check-in calls to enhance communication between CCM and ADATC departments

VI. PIHP Strengths and Opportunities for Improvement

A. Strengths

Strengths indicate the PIHPs demonstrated proficiency on a given activity and can be identified regardless of validation status. The lack of an identified strength is not to be interpreted as a shortcoming of the PIHP. The strengths identified across the six PIHPs are:

- Data analysis was used to support study rationale
- Data collection methods and data analysis plans were appropriately documented
- Data sources were specified
- Qualified personnel were involved in study development and management
- Clear documentation of barriers and interventions to address the barriers
- Study aims/questions documented in the PIP reports

One area of improvement from the previous EQR that was demonstrated across all six PIHPS in the current review was the reporting of indicators. Therefore, one element that was an opportunity last year is considered a strength of the PIPs this year:

- Clear definition of indicators, including baseline goal and benchmark rates

B. Opportunities for Improvement

Opportunities for Improvement are generated for PIHPs when documentation for an evaluation element does not meet minimum requirements. All PIHPS had at least one PIP that showed a decline in the outcomes and one PIHP submitted a report with results that were not clearly presented. Based on the validation of the PIPs, CCME identified the following areas for improvement:

- Clear presentation of the results in Table and Graphic formats
- Improvement in indicator/outcome rates by initiation of new interventions or revisions to active interventions