The Carolinas Center *for* Medical Excellence

# 2022 Annual Summary Report for Performance Improvement Projects

April 21, 2023

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 2022-2023. 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.

# 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 2022 PIP validation review year, CCME validated 26 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

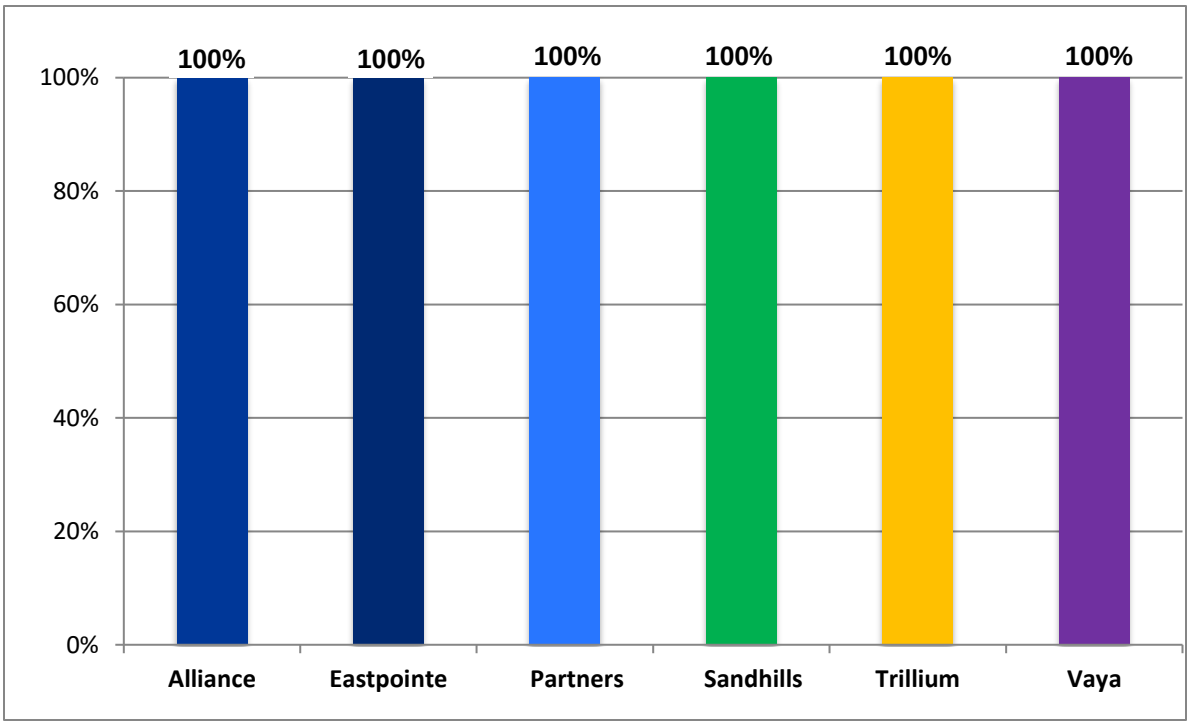
The validation decision categories for each PIP submitted, as well as the total number of PIPs validated for each PIHP are shown in Table 3.

**Table 3: Validation Decision Categories**

| PIHP | High Confidence | Confidence | Low Confidence | Not Credible | Total # of PIPs Validated |
|---|---|---|---|---|---|
| **Alliance** | 6 | - | - | - | 6 |
| **Eastpointe** | 3 | - | - | - | 3 |
| **Partners** | 5 | - | - | - | 5 |
| **Sandhills** | 4 | - | - | - | 4 |
| **Trillium** | 5 | - | - | - | 5 |
| **Vaya** | 3 | - | - | - | 3 |

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 Super Measure – State DMH MH* | 79/79 = 100% | High Confidence in Reported Results |
| 7-Day Super Measure – State DMH SUD* | 73/74 = 99% | High Confidence in Reported Results |
| 7-Day Super Measure – Medicaid DHB SUD* | 73/74 = 99% | High Confidence in Reported Results |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)* | 79/79 = 100% | High Confidence in Reported Results |
| Diabetes Screenings for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)* | 79/79 = 100% | High Confidence in Reported Results |
| Transitions to Community Living (TCL) PCP Visits Improvement | 84/84 = 100% | High Confidence in Reported Results |
| **EASTPOINTE** | | |
| Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)* | 79/79 = 100% | High Confidence in Reported Results |
| Decrease Emergency Department (ED) admissions for Active Members to 20%* | 79/79 = 100% | 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 |

| PROJECT | VALIDATION SCORE | VALIDATION DECISION |
|---|---|---|
| **PARTNERS** | | |
| Initial NC TOPPS Interview | 73/74 = 99% | High Confidence in Reported Results |
| TCL Housing Loss Reduction | 79/79 = 100% | High Confidence in Reported Results |
| Registry of Unmet Needs* | 73/74 = 99% | High Confidence in Reported Results |
| Increase Opioid-Initiated Engagement* | 73/74 = 99% | High Confidence in Reported Results |
| Initiation & Engagement of Substance Use Members* | 73/74 = 99% | High Confidence in Reported Results |
| **SANDHILLS** | | |
| NC-TOPPS Interview Data Accuracy | 79/79 = 100% | High Confidence in Reported Results |
| Routine Appointments Kept | 73/74 = 99% | High Confidence in Reported Results |
| TCLI Timeliness Documentation Submission | 79/79 = 100% | High Confidence in Reported Results |
| Assure Consistent Connection to Community Services* | 80/80 = 100% | High Confidence in Reported Results |
| **TRILLIUM** | | |
| Super Measure MH* | 73/74 = 99% | High Confidence in Reported Results |
| Super Measure SU* | 79/79 = 100% | High Confidence in Reported Results |
| ED Utilization* | 73/74 = 99% | High Confidence in Reported Results |
| MST Utilization* | 73/74 = 99% | High Confidence in Reported Results |
| TCLI 90 Day Contact | 79/79 = 100% | High Confidence in Reported Results |
| **VAYA** | | |
| TCLI Housing Retention | 79/79 = 100% | High Confidence in Reported Results |
| Increase follow-Up after Discharge for Mental Health | 79/79 = 100% | High Confidence in Reported Results |
| Access to Care* | 73/74 = 99% | 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 improvements in outcomes and two PIPs showed a decline in the outcomes. The two PIPs that received a Recommendation were the 7 Day DHB SUD and 7 Day DMH SUD PIPs.

| Projects | Status | Interventions |
|---|---|---|
| **7 DAY DHB SUD** | The rate had declined to 31% after a rate of 37% in March 2022, and the goal is 40%. | New care management process, Peer Bridger Program, follow up phone calls |
| **7 Day DMH MH** | The most recent rate improved from 28% in May 2022 to 33% in June 2022. The goal is 40%. | Provider scorecard review, new care management process, follow up phone calls, value-based incentives, telehealth, Peer Bridger program |
| **7 Day DMH SUD** | The latest remeasurement showed a decline from 29% in May 2022 to 27% in June 2022. The goal is 40%. | Streamlining of processes to contact patients, value-based incentives, provider communication and education programs, assertive engagement, Provider scorecard review |
| **APM** | The most recent measurement showed no change, with July and August 2022 having a 32% rate (Goal: 35%) | HealthCrowd campaign for awareness, Point of Care testing, Provider scorecards, staff education, provider data reports |
| **SSD** | The most recent remeasurement period showed a slight improvement from 67% in July 2022 to 68% in August 2022. The goal rate is 81%. | HealthCrowd campaign for awareness, Point of Care testing, staff education, data sharing |
| **TCLI PCP Visits** | The rate improved from 89% in October 2022 to 91% in November 2022. This is above the goal rate of 80% and has been above the goal rate for the last 3 measurements. | PCP visit tracking, staff education, provider communication programs |

## B. Eastpointe

Of the 3 PIPs, all 3 showed improvement in outcomes or sustained previous rates and no PIPs showed a decline in the outcomes. No Recommendations or corrective actions were offered.

| Projects | Status | Interventions |
|---|---|---|
| **Increase Diabetes Screening for People (18-64) With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications to 80% (SSD)** | The SSD rate slightly increased from 65.5% to 66.7% (goal is 80%). For the SMD measure, the goal is 70% and the rate increased slightly from 37% in 2020 to 37.6% in 2020/2021. Both measures have shown a steady, albeit slight improvement over the past three measurement periods. | Provider Enrichment Forum, Provider Meeting on the importance of including Diabetes screening/monitoring as a goal on the member's Person-Centered Plan (PCP), Mailing letters to providers related to use of antipsychotics. |
| **Decrease Emergency Department (ED) admissions for Active Members to 20%- Clinical** | The most recent measurements showed a rate of 38% in Feb 2022 which declined to 34% in March 2022, thus, the PIP has shown improvement. | MH/SU Care Specialist daily calls to ED, Hospital Transition Team members to assist with discharge planning, interdepartmental meetings to address ED re-admissions concerns, Provider Self-Audit Tool, and data review and technical assistance calls with ACTT Providers |
| **Decrease Percentage of Members who Separate from TCLI Housing to 20% or Less Annually - Non Clinical** | The FY 2020 and FY2021 rates were at the 20% rate for the two most recent remeasurement periods. There was no increase or decrease (improvement) in the rate. | Use of My Strengths app with members, Permanent Supportive Housing (PSH) training, Motivational Interviewing training, and Engagement trainings, new inspectors, and ADANC Community Inclusion provider |

## C. Partners

A total of five PIPs were submitted for Partners. Of those five, four showed a decline in the outcome rate, one showed improvement in the outcome.

| Projects | Status | Interventions |
|---|---|---|
| **Initial NC TOPPS Interview** | There was a decrease from August 2022 (38.4%) to September 2022 (37.2%). The goal is 80%. | Produce individualized provider scorecards; Create a distribution list of NC-TOPPS Super Users; 1:1 meeting with providers for technical assistance; enhance the knowledge base of NC-TOPPS; NC TOPPS workgroup webinar; |
| **TCL Housing Loss Reduction** | The total who lost housing was 71 as of June 2022; the percentage re-housed was 44% which exceeds the comparison goal rate of 13%. | Visit TCLI members monthly; Discuss each member monthly with service providers; Review eviction notices and County data; Increase communication with members and service providers; Address social determinants of health issues. |
| **Registry of Unmet Needs** | The most recent quarterly rates showed a decline from July-Sep 2022 at 41% to 39% during Oct-Dec 2022. The goal rate is 48% for the percentage of IDD members on the registry of unmet needs engaged in services. | Long-term Community Support, Community Living and Supports, Day Supports, In-Home Skills building |
| **Increase Opioid-Initiated Engagement** | The goal is 79.21% for non-Medicaid and the results showed a decline from Jul-Sep 2022 at 64.8% to Oct-Dec 2022 at 62.69%. The goal is 87.58% for Medicaid, and the results showed improvement from 64.8% in Jul-Sept 2022 to 65.92% in Oct-Dec 2022. | Ongoing local housing initiatives and additional recovery support services; incentives for members that remain in treatment for 180 days; Provide training and technical assistance to providers; PSS (Peer Support Services) in the OTPs (Opioid Treatment Program; office-based opioid treatment service; |
| **Initiation & Engagement of Substance Use Members** | The results showed a slight decline from Jul-Sept 2022 at 33.98% to 33.19% in Oct-Dec 2022. The goal is 37.96%. | Incentives for members that remain in treatment for 180 days; training and technical assistance to providers on an ongoing basis; Educate the provider community about MAT; Ongoing local housing initiatives and recovery support services; report that includes providers' specific data regarding the engagement of services; communication with providers about flexibility codes |

## D. Sandhills

A total of four PIPs were submitted for Sandhills. Of those four, one showed a decline in the outcome rate, three showed improvements in the outcome. The PIP showing a decline was Routine Appointments Kept.

| Projects | Status | Interventions |
|---|---|---|
| **NC-TOPPS Interview Data Accuracy** | The most recent rate was 83.3% with no errors (724 out of 869 consumer interviews) which is an improvement from the Q3 2021/2022 rate of 82.3%. The goal is 85%. | Licensed Care Coordinators assigned to all providers, additional providers to assist in FBC, education and training for low-performing providers |
| **Routine Appointments kept** | The goal is 66%. The most recent measure was for Q4 2021/2022 and showed a rate of 19% (7 out of 36 routine appointments that were kept). This was a decline from the Q3 2021/2022 rate of 38% (9 out of 24 appointments). The rate of 19% is the lowest since the start of the PIP. | Education and training for staff, continued monitoring |
| **TCLI Timeliness Documentation Submission** | The goal is to reduce the late entry error rate to 0% for care coordination documentation, so lower rates are better for this PIP. The report shows a rate of 1.81% of late entries for Q4 2021/2022 (49 out of 2713). This is a decrease from the Q3 2021/2022 rate of 2.45% (76 out of 3098). Thus, the most recent rate showed improvement. | NC-TOPPS training presentation; Reminders given at the quarterly Provider Forum. Training Coordinator to work on creating a Virtual training for all providers |
| **Assure Consistent Connection to Community Services*** | The most recent quarterly rate for the overall population for Q1 2021/2022 was 56% (121 connected to a community provider out of 216) compared to the Q4 2020/2021 rate of 55% (39 out of 71 members). The goal rate is 70%. The lowest performing provider had a rate of 28% in Q4 2020/2021 which decline to 0% in Q1 2021/2022. The overall rate showed improvement from the previous quarter. | Reminder texts and reminder calls; Follow-up calls to attempt to get the member linked to services within 14 days; 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 |

## E. Trillium

Five PIPs were validated for Trillium. Three of the five PIPs did not show improvement. The three PIPs not showing improvement were Supermeasure MH, ED utilization, and MST Utilization.

| Projects | Status | Interventions |
|---|---|---|
| **Super Measure MH*** | DHB rates declined from 48.5% in Apr – Jun 22 to 38.6% in Jul -Sept 22. DMH rates decline from 21.7% to 18.5%. The goal is 45% and local data were used since validated State data were not available as of the report submission. | Provider meetings, quarterly meetings with discharge providers, incentive contract, data sharing, provider education, and member engagement |
| **Super Measure SU*** | DMH 2022 rates are reported. The most recent rate of 25.5% for July-Sept 22 was an improvement over the Apr – June 2022 rate of 24.3%. The goal is 45%. | One-on-one meetings with providers with high volume of served members and low follow-up rates, focused quarterly meetings with discharging providers, incentive contract for FBC, data sharing with providers regarding follow-up rates |
| **ED Utilization** | For measure #1 (reduce number to .66% or lower), the rate declined slightly from 1.48% in Jan-March 2022 to 1.46% in Apr-Jun 2022. For measure #2 (increase follow-up treatment percentage after ED visits to 80% or higher), the rate decline from 84.7% in Q1 22 to 82.28% in Q2 2022. For measure #3 (decrease number of IIH and ACTT members utilizing ED to 7.79% or lower), the rate improved (declined) from Q1 2022 at 8.58% to Q2 220 (8.11%). | Wellness Recovery Homes, Substance Use Disorder host homes for transitional living residences, Project Transitions for SPMI members, ED dashboard |
| **MST Utilization** | The most recent quarterly rate showed a rate of 5.63% which is a decline from the Jan-Mar 2022 rate of 9.03%. The goal is to increase the services rate to 14.7%. | Location analysis, MST service engagement/provider outreach, and staffing pattern review |
| **TCLI 90 Day Contact PIP** | The goal is 98%. The most recent rate improved from 90.5% in Sept 2022 to 91.7% in Oct 2022. This is still below the goal rate but is improving toward it after a low of 63.8% in June 2022. | Report pulled from TCLD to verify the status of In-Reach members; weekly reports sent to the In-Reach provider; staff monitoring of In-Reach provider's notes |

### F. Vaya

Vaya submitted 3 active PIPs submitted and one PIP that was submitted but was still in development, therefore, it was reviewed in lieu of validating. Of the 3 PIPs validated, two showed improvement or were above the goal rate and one showed a decline, which was the Access to Care PIP.

| Project(s) | Status | Interventions |
|---|---|---|
| **TCLI Housing Retention** | In the most recent two measurement periods, the number housed showed improvement from 12 housed/ 12 lost to 25 housed and 6 lost in June 2022. The goal is to have net gain of 29 housed. | Mental health specialized probation offices, text message reminders, care management and DPS processes, education for probation and complex care management staff, iPads to DPS for real-time information on members |
| **Increase follow-Up after Discharge for Mental Health** | The goal is to attain a 40% follow up rate. The most recent rate declined from 58% to 56%, although it remains above the goal rate. | Data analysis, front-line team member feedback, meeting 8/22/22 for intervention plan |
| **Access to Care*** | The most recent rate showed a decline from 43.2% in Q2 2021/2022 to 40% in 3rd quarter. The goal is 50% with a routine appt within 14 days. | Peer Bridger program, crisis services, onsite care management for some facilities, education on Peer Bridger Program |

## 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
- Clear definition of indicators, including baseline goal and benchmark rates
- Clear presentation of the results in Table and Graphic formats

## B. Opportunities for Improvement

Opportunities for Improvement are generated for PIHPs when documentation for an evaluation element does not meet minimum requirements. Five of the six PIHPS had at least one PIP that showed a decline in the study indicators. Based on the validation of the PIPs, CCME identified the following area for improvement across the PIHPs:

- Improve indicator/outcome rates by creating fewer and more focused interventions to allow monitoring of specific actions that impact the indicator rates.