Quality Improvement Plan
Name: Northeast Health Partners
RAE: 2
Date: December 20, 2021

1. Purpose/Mission Statement

Organizational Purpose

The organizational purpose for Northeast Health Partners, LLC (NHP) has not changed. NHP is the Regional Accountable Entity (RAE) for Region 2. Representing 10 counties in the northeast part of Colorado, NHP's territory spans more than 20,000 square miles and includes more than 90,000 eligible members. The region was founded by four provider organizations that serve the region – Sunrise Community Health, Salud Family Health Centers, North Range Behavioral Health, and Centennial Mental Health Center. NHP also utilizes Beacon Health Options as its contracted Administrative Services Organization (ASO).

The Quality Improvement (QI) program at NHP is responsible for programming and initiatives that work to improve health outcomes for Health First Colorado (Medicaid) members, as well as overall health care management. Working collaboratively with Beacon Health Options, QI programming spans across business intelligence, practice transformation, care coordination, and population health to ensure programmatic decision-making is data-driven, efficient, and aligned.

As with previous quality plans, this plan also serves as NHP's blueprint for the state fiscal year (SFY) 2021-2022 (i.e., July 1, 2021 – June 30, 2022). This plan includes goals and activities that will be prioritized for the fiscal year. As the region continues to be impacted by the COVID-19 pandemic, any activities specific to the pandemic are noted throughout the plan where applicable.

Overall Quality Health Strategy Mission and Vision

The mission of Northeast Health Partner's QI Department also has not changed. It supports the organization's chosen prioritization of assuring high value service delivery, focusing on seamless, coordinated care for Health First Colorado Medicaid member and health care providers. In addition, the QI Department strives to support efforts to eliminate waste and fragmentation between service providers across the broader system.

The FY20-21 quality plan noted the *Science of Improvement and Deming's Theory of Profound Knowledge*[1] as key components of the quality strategy. This has not changed between fiscal years. As noted previously, the four basic tenets of Deming's theory are:

1. To make an "improvement," it's critical to understand the system as a whole and the various components within the system.

2. Variation within a system is natural, and data is necessary to understand the reason for the variation.

[1] Langley, G.J. et al. (1996). The Improvement Guide: A practical approach to enhancing organizational performance. San Francisco: Jossey Bass.

3. The "science of improvement" applies a scientific method to improvement by making predictions about implemented changes. The more the system is understood and the more the variation is explained (by data), the more accurate the prediction will be.

4. Understanding that people are parts of system improvement and understanding human behavior is important for successful improvement efforts.

NHP's approach to delivering this culture exists within the Total Quality Management (TQM) framework, a model focused on meeting the needs of those it serves while engaging the entire organization to embrace quality improvement. The tenets of a TQM system are outlined below to include a focus on the customer (in this case NHP's Medicaid members and clinical partners), integrating smaller systems, engaging staff and people, controlling processes, strategic thinking, continual improvement, fact-based decision-making, and effective communication.[2]

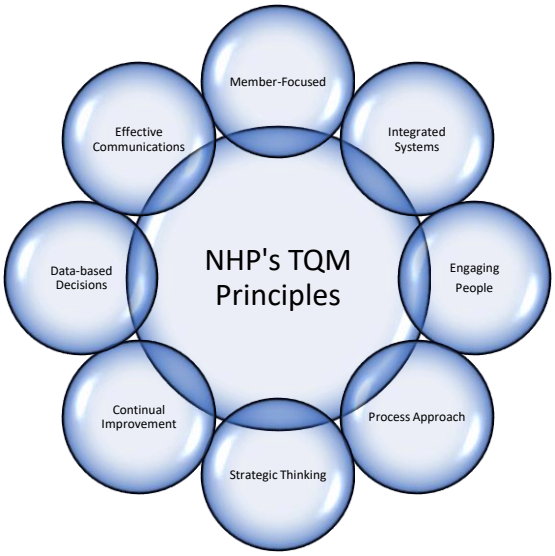

Figure 1. Total Quality Management Framework

In alignment with the Department's Quality Strategy and the TQM Principles, NHP is committed to understanding smaller systems within the larger framework, engaging members and providers to understand need and to establish partnerships for improvement, establishing transparency in measurement, data reporting, the distribution of payment incentives of key performance markers as well as the data used in evaluating performance and effectiveness, and continually looking for ways to improve performance.

[2] Westcott, R.T. (2014). The Certified Manager of Quality/Organizational Excellence Handbook. 4th Edition. Milwaukee: ASQ Press.

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2. Yearly Objectives/Top Priorities

The QI Program at NHP established key initiatives for SFY21/22 through an evaluation of its accomplishments to-date, and the identified gaps and barriers observed during the last fiscal year. Initiatives for SFY21/22 are noted at a high level below in Table 1.

Table 1. Key Initiatives for SFY21/22

Project	Goal / Activity
411 Audit	• Improve on our inter-rater reliability with HSAG overreads.
All performance measures	• Establish a single source for reporting and visualizing performance on KPIs, BHIP, Performance Pool measures. • Improve access to performance reports and action items across KPIs and incentive measures. • Refine and improve enhanced reporting through Power BI and/or other systems to enable performance visualizations and deeper-level performance assessments. • Partner with individual clinics/sites to establish targeted performance improvement activities for lagging performance indicators. • Solidify the PMAP process for targeted performance improvement efforts.
Behavioral Health Incentives	• Continue performing at or above the regional target for SUD Engagement and 7-Day Follow-Up after an ED Visit for SUD measures. • Achieve regional goals for the BH Screen/Assessment for Foster Care Members. • Establish clinic-level performance improvement initiatives for lagging BHIP performance. • Increase the total volume of depression screens billed in primary care helping achieve the gate measure associated with the depression screen incentive measure. • Explore BH Assessments with Members in Foster Care to improve performance. • Solidify the PMAP process for targeted performance improvement efforts.
Performance Pool	• Maintain strong performance in Extended Care Coordination. • Maintain strong performance in DOC
PAC	• Achieve all milestones associated with PAC work with scores above 90.

Performance Improvement	• Establish independent performance improvement projects to meet KPI, BHIP, and PP measures to meet:
	  ○ 3 out of 5 KPI metrics at a Tier 2 level
	  ○ 3 out of 5 BHIP measures
	  ○ 3 out of 7 Performance Pool Measures

PIP	• Study the impact of the PIP plan at Sunrise on Depression Screening and Follow-up measures
ED Visits	• Understand the growing trend in ED utilization that began in February of 2021.

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Project	Goal / Activity
Practice Transformation Program	• Expand on Practice Transformation work from SFY21/22
Hospital Transformation Program	• Work with hospitals to identify current processes and streamline processes in alignment with the Hospital Transformation Program

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3. Program Leadership

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4. SWOT Analysis & Action Plan

Note: The Department has not requested this.

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Goal	Fiscal Year (21/22) New & Ongoing Objectives	Targeted Due Date	Update
Performance Improvement Projects			
Increase rates of Depression Screen and Follow-ups at Sunrise Community Health	a) Establish data analysis and performance visualizations b) Establish targeted performance improvement activities as necessary c) Ensure statistically significant improvement for both screening and follow-up rates	June 30, 2022	NHP has approval for and began collecting performance data for module 3. We will assess for statistical significance and engage Sunrise for any PI activities if performance is not meeting goals.
411 Quality Improvement Project (QuIP)	Meet all project requirements associated with the 411 Quality Improvement Project (QuIP).	June 30, 2022	As in past 411 audits, NHP performed very well across the three service categories. NHP will engage in the CY22 411 audit. Based upon audit results, NHP will tailor training specific to the areas of improvement found in the audit. In addition, NHP is currently engaged in the 411 QUIP focusing on psychotherapy services.
Collection and Submission of Performance Measurement Data			
Maintain Tier 2 KPI Performance	a) Identify and understand ED visits volume growth from February b) Continue performing at Tier 2 levels for ED Visits and Prenatal Care	June 30, 2022	NHP has been performing at a Tier 2 level since April of 2020 for ED Visits, and August of 2019 for Prenatal Engagement. The pandemic has impacted ED visits, but the volume trends have risen slowly in the region since the spring of 2021. NHP is interested in understanding the rise in ED volume (whether due to COVID variants or a more open economy) to help maintain Tier 2 performance.
Meet Tier 2 Performance for at Least One New KPI	a) Assess performance at site/clinic levels b) Initiate targeted PI activities with sites/clinics if necessary	June 30, 2022	NHP began a process to develop specific, clinic level performance improvement projects via the Performance Measures Action Plan (PMAP) process. Utilizing a review of clinic level performance data, NHP will offer support to clinics in conducting individual performance improvement projects across the network.

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Exceed Performance Thresholds for SUD Engagement	a) Identify and understand performance trends and improvement opportunities b) Initiate targeted PI activities with sites/clinics if necessary	June 30, 2022	SUD engagement exceeded the target beginning in March of 2021. NHP hopes to continue this trend and engage in targeted PI activities as necessary, but challenges exist in data tracking and matching across systems since HCPF calculates this rate for the BH incentives. RAEs have struggled to match HCPF's rates exactly due to different interpretations of the specifications and different systems. SUD is an episode of interest in the SFY21/22 PAC Plan which can help provide insight into performance, cost reduction, and strategy.
Exceed Performance Thresholds for Depression Screening Follow-Up	a) Identify and understand performance trends and improvement opportunities b) Report on gate measure performance c) Initiate targeted PI activities with sites/clinics if necessary	June 30, 2022	NHP has exceeded the depression screening target since November of 2020, but has not met the gateway measure for this metric. Gate measure performance will be reported in SFY21/22, but challenges exist with accurately matching state codes for calculating this metric. NHP is working with a clinic to explore screening and follow-up performance, and hopes that this tarted PI activity impacts our performance in the gateway measure.
Continue exceeding Performance Thresholds for Extended Care Coordination	a) Identify and understand performance trends and improvement opportunities b) Establish mitigation strategies as needed	June 30, 2022	Extended Care Coordination has exceeded the performance threshold since November of 2019. NHP opted to work with the State to rescope the complex member definition in Q2 of SFY21/22. New baselines and targets will impact performance, but NHP hopes to continue its performance trend with the new definition and engage in targeted PI activities as necessary throughout SFY21/22.

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Continue exceeding Performance Thresholds for BH Engagement Following DOC Discharge	a) Identify and understand performance trends and improvement opportunities b) Establish mitigation strategies as needed	June 30, 2022	BH Engagement after DOC release exceeded the threshold 8 out of the last 10 months in SFY 20/21. NHP hopes to continue this trend and engage in targeted PI activities as necessary.
Achieve full points for Potentially Avoidable Complications (PAC)	Achieve 90% or more of available points for PAC deliverables	Quarterly	PAC episodes of care have been selected for SFY21/22 to include Pregnancy, Diabetes, and SUD. All milestones were achieved for SFY20/21, and NHP looks to continue this result for SFY21/22.
Establish Targeted Reporting and Performance Improvement with Clinics	a) Pilot a report detailing clinic performance and action items from the Data Analytics Portal (DAP) b) Identify alternative data sources for KPI, BHIP, and Performance Pool performance communications c) Create targeted PI activities in partnership with clinics	June 30, 2022	NHP's QI Director and IT Director with support Beacon QM team are establishing a pilot program in early SFY21/22 for RAE 2 providers to be able to directly access their performance data via the DAP. The effort aligns with the NHP's Total Quality Management (TQM) culture and key initiatives/ objectives along with the Performance Measures Action Plan (PMAP) to allow performance data to be more accessible to stakeholders.
Member Experience of Care			
Utilize CAHPS and ECHO surveys	a) Meet or exceed satisfaction results from SFY20/21. b) Present survey results to quality committees for additional input and for performance improvement activities.	June 30, 2022	CAHPS survey results have been received and were presented at two regional meetings. NHP is working to explore the results with surveyed sites to identify interventions that aim to increase satisfaction in areas identified for improvement.

Continue Grievances and Appeals Processes and Oversight	a) Continue reporting on grievances and appeals trends to quality and clinical leadership (at least quarterly). b) Continue to utilize the Member Engagement Advisory Committee to ensure additional level of member experience is incorporated into quality activities.	June 30, 2022	The member services team trends all grievances and appeals on a quarterly basis and delivers the trending reports to the quality improvement and clinical team. They will continue to report the trending on grievances and engage shareholders on how to target any identified trends. The member services team meets with the Member Services Subcommittee on a quarterly basis to provide oversight on the complaints received by the shareholder advocates. The member services team will continue to host quarterly Member Experience Advisory Council meetings to obtain member input on their experience in health care.
Under and Over Utilization of Services			
Continue Monitoring the BH Penetration Rate	a) Continue performing at or above the target. b) Identify special populations for reporting on penetration rates, including foster care and individuals with Diabetes and comorbid depression and anxiety.	June 30, 2022	BH penetration is currently reported quarterly. Rolling penetration rates for SFY20/21 are 18.5%, but understanding specific disease rates may inform clinical decisions. Diabetes-specific rates support PAC activities around diabetics with comorbid depression and anxiety; a member population with high ED utilization and high ED costs.
Improve and Monitor Hospital Readmissions Performance	a) Continue reporting on 30-day hospital readmissions. b) Establish a performance improvement opportunity on suboptimal performance.	June 30, 2022	Current reports exist for 30-day readmissions and are reported quarterly. Q4 of SFY20/21 had an aggregated penetration rate of 9.4%, but there are opportunities for improvement with some facilities.

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Improve and monitor Average Length of Stay (ALOS) performance	a) Continue reporting on ALOS. b) Establish a performance improvement opportunity on suboptimal performance.	June 30, 2022	Current performance is reported monthly in the UM Committee. ALOS has generally had a downward trend between May and October of 2021, and NHP hopes to continue this trend.
Improve and monitor Inpatient Utilization	a) Continue reporting on inpatient utilization. b) Establish a performance improvement opportunity on suboptimal performance.	Quarterly	Current performance is reported monthly in the UM Committee. Daily Census has been relatively flat to end SFY20/21, but is seeing some rise in inpatient utilization starting in October of 2021.
Quality and Appropriateness of Care Furnished to Members			
Enhance and Continue Care Coordination Audits	a) Establish data collection methods to track results on audited standards. b) Trend performance to proactively identify opportunities and training needs.	June 30, 2022	Care coordination audits were conducted in late SFY20/21 and a new audit template was created for SFY21/22
Quality of Care Concerns			
Continue Quality of Care Processes and Oversight	a) Finalize the document for reporting QOC issues to HCPF. b) Send quarterly reports HCPF.	Quarterly	Meetings to evaluate quality of care issues and adverse events are scheduled monthly or as needed. The document to use for reporting issues was agreed upon with the State in Q2 of SFY21/22 and the first quarterly reports were submitted in Q2 of SFY21/22.
External Quality Review			

Meet all Requirements Associated with the EQRO Audits	Comply with all site review activities for SFY21/22.	June 30, 2022	Stemming from the FY21 EQRO audit, three standards were issued a corrective action. These standards were: Standard VII—Provider Participation and Program Integrity Standard VIII—Credentialing and Recredentialing Standard IX—Subcontractual Relationships and Delegation NHP has submitted the CAP plan for each of the corrective actions identified in the SFY20/21 EQRO audit. The SFY21/22 EQRO audit will take place in March of 2022.
Advisory Committees and Learning Collaboratives			
Maintain the Quality Management Committee Activities	Maintain bi-monthly Quality Management (QM) committee to monitor QI Program initiatives throughout the region.	Bimonthly	QM committee meets bi-monthly since September of 2020, and will continue to meet on this schedule for SFY21/22. Commonly discussed topics include regional and state updates, KPI and BHIP metric performance, and performance improvement activities in addition to other pressing Quality initiatives.
Maintain Regional Program Improvement Advisory Committee (PIAC)	a) Incorporate population health initiatives into the meeting content. b) Align activities and content to the State PIAC.	Quarterly	The RAE 2 Regional PIAC meets quarterly. Topics routinely include State PIAC discussion topics such as Public Health Emergency (PHE) ending, performance measure changes, and subcommittee updates.
Quality and Compliance Monitoring Activities			

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Meet all Encounter Data Validation Audit Requirements.	Improve overread scores with HSAG.	Spring 2022	Internally-calculated inter-rater reliability (IRR) was 86.7% and perfect agreement was met in 32 of 36 data elements in 2021. NHP will look to meet or exceed these scores for SFY21/22.
Continue Behavioral Health Compliance Auditing	a) Establish data collection methods to track results on audited standards. b) Trend performance to proactively identify opportunities and training needs.	Monthly	The Department expanded SUD benefits to include inpatient and residential components such as withdrawal management to the continuum of outpatient SUD services currently available. Policies and procedures will continue to be updated to ensure alignment with State and Medicaid requirements, and providers will continue to be audited based on all standards.
Alternative Payment Model			
Hospital Transformation Program	a) Identify processes and process variations with reporting to the RAE c) Identify technologies for implementation.	June 30, 2022	This is a new Quality initiative for SFY21/22.
Practice Transformation	a) Practices achieve 90% of milestones. d) PT Coaches incorporate DAP performance in practice check-ins.	June 30, 2022	This was a new initiative for SFY20/21. Thirteen of 18 sites achieved all milestones in SFY20/21. NHP evolved the program to help build a culture of quality within practices for SFY21/22 and looks to improve on the previous fiscal year's scores for the new fiscal year. NHP will utilize Practice Transformation Coaches to incorporate DAP performance in practice transformation meetings.