Colorado
Accountable Care Collaborative

Fiscal Year 2015–2016 Colorado PIP Validation Report

Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay

for

Community Health Partnership—Region 7

April 2016

for

Validation Year 2

This report was produced by Health Services Advisory Group, Inc. for the Colorado Department of Health Care Policy & Financing.

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TABLE OF CONTENTS

1. BACKGROUND

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with federal regulations and quality improvement standards. According to the BBA, the quality of health care delivered to Medicaid members in MCOs and PIHPs must be tracked, analyzed, and reported annually. The Colorado Department of Health Care Policy & Financing (the Department) has contractual requirements with each MCO and behavioral health organization (BHO) to conduct and submit performance improvement projects (PIPs) annually.

The Colorado Department of Health Care Policy and Financing (the Department) introduced the Accountable Care Collaborative (ACC) Program in spring 2011 as a central part of its plan for Medicaid reform. The ACC Program was designed to improve the client and family experience, improve access to care, and transform incentives and the health care delivery process to a system that rewards accountability for health outcomes. Central goals for the program are (1) improvement in health outcomes through a coordinated, client-centered system of care, and (2) cost control by reducing avoidable, duplicative, variable, and inappropriate use of health care resources. A key component of the ACC Program was the selection of a Regional Care Collaborative Organization (RCCO) for each of seven regions within the State. The RCCOs provide medical management for medically and behaviorally complex clients; care coordination among providers; and provider support such as assistance with care coordination, referrals, clinical performance, and practice improvement and redesign.

As one of the mandatory external quality review activities under the BBA, the Department is required to validate the PIPs. To meet this validation requirement, the Department contracted with Health Services Advisory Group, Inc. (HSAG), as the external quality review organization. The primary objective of the PIP validation is to determine compliance with requirements set forth in the Code of Federal Regulations (CFR) at 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities to increase or sustain improvement.

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG evaluates the following components of the quality improvement process:

1. The technical structure of the PIPs to ensure the RCCO designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs.

HSAG's review determined whether a PIP could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring real and sustained improvement.

2. The outcomes of the PIPs. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. Evaluation of each PIP's outcomes determined whether the RCCO improved its rates through the implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results) and, through these processes, achieved statistically significant improvement over the baseline rate. Once statistically significant improvement is achieved across all study indicators, HSAG evaluates whether the RCCO was successful in sustaining the improvement. The goal of HSAG's PIP validation is to ensure that the Department and key stakeholders can have confidence that reported improvement in study indicator outcomes is supported by statistically significant change and the RCCO's improvement strategies.

PIP Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas.

For fiscal year (FY) 2015–2016, **Community Health Partnership** (**CHP**) continued its ***Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay*** PIP. The topic selected addressed CMS' requirements related to quality outcomes—specifically, access to care and services.

PIP Summary

For the FY 2015–2016 validation cycle, the PIP received an overall validation score of 88 percent and a *Met* validation status. The focus of the PIP is to reduce all-cause readmissions within 90 days of inpatient discharge among homeless members. The PIP had one study question that **CHP** stated: "Does providing 14-day medical respite care to homeless RCCO Medicaid clients decrease the percentage of all-cause readmissions within 90 days of inpatient discharge?" The following table describes the study indicator for this PIP.

Table 1–1—Study Indicator

PIP Topic	Study Indicator
Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay	The rate of all-cause readmissions within 90 days of hospital discharge to a 14-day medical respite program among homeless members.

Validation Overview

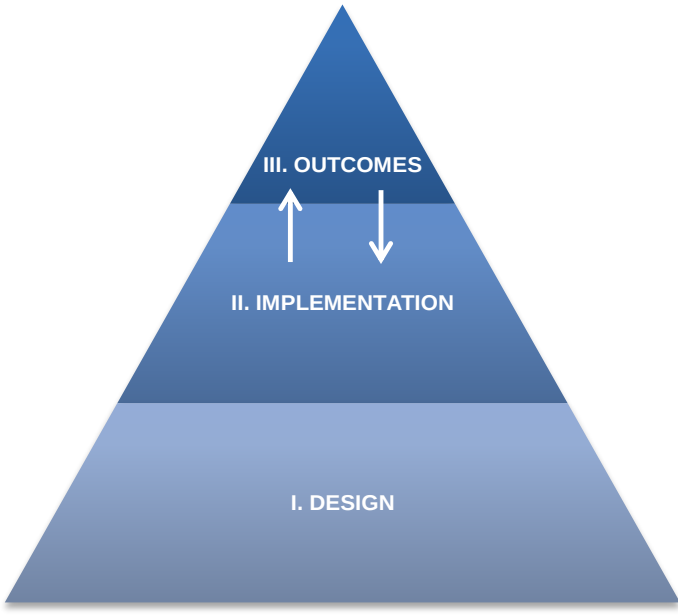
HSAG obtained the information needed to conduct the PIP validation from **CHP**'s PIP Summary Form. This form provided detailed information about the RCCO's PIP related to the activities completed and HSAG evaluated for the FY 2015–2016 validation cycle.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed (NA)*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A RCCO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

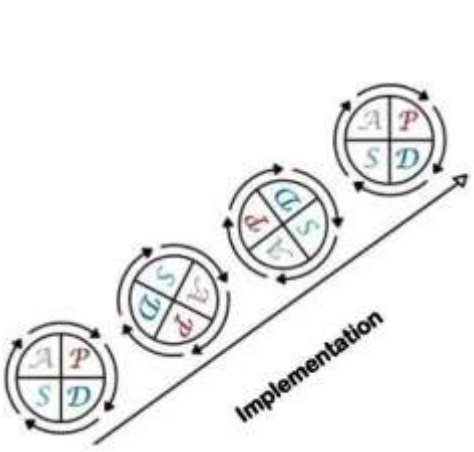
Figure 1–1 illustrates the three study stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study topic, question, indicators, population, sampling, and data collection. To implement successful improvement strategies, a strong study design is necessary.

Figure 1–1—PIP Stages



Once **CHP** establishes its study design, the PIP process moves into the Implementation stage. This stage includes data analysis and interventions. During this stage, the RCCOs analyze data, identify barriers to performance, and develop interventions targeted to improve outcomes. The RCCOs should incorporate a continuous or rapid cycle improvement model such as the Plan-Do-Study-Act (PDSA) to determine the effectiveness of the implemented interventions. The implementation of effective improvement strategies is necessary to improve PIP outcomes.

Figure 1–2—PIP Stages Incorporating the PDSA Cycle



The PDSA cycle includes the following actions:

- **P**lan—conduct barrier analyses; prioritize barriers; develop targeted intervention(s) to address barriers; and develop an intervention evaluation plan for each intervention
- **D**o—implement intervention; track and monitor the intervention; and record the data
- **S**tudy—analyze the data; compare results; and evaluate the intervention's effectiveness
- **A**ct—based on the evaluation results, standardize, modify, or discontinue the intervention

The final stage is Outcomes, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. The RCCO should regularly evaluate interventions to ensure they are having the desired effect. A concurrent review of the data is encouraged. If the RCCO's evaluation of the interventions, and/or review of the data, indicates that the interventions are not having the desired effect, the RCCO should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

This year, the PIP validation process evaluated the technical methods of the PIP (i.e., the study design). Based on its technical review, HSAG determined the overall methodological validity of the PIP.

Table 2–1 summarizes the PIP validated during the review period with an overall validation status of *Met*, *Partially Met*, or *Not Met*. In addition, Table 2–1 displays the percentage score of evaluation elements that received a *Met* score, as well as the percentage score of critical elements that received a *Met* score. Critical elements are those within the validation tool that HSAG has identified as essential for producing a valid and reliable PIP. All critical elements must receive a *Met* score for a PIP to receive an overall *Met* validation status. A resubmission is a RCCO's update of a previously submitted PIP with modified/additional documentation.

RCCOs have the opportunity to resubmit the PIP after HSAG's initial validation to address any deficiencies identified. The PIP received a *Partially Met* overall validation status when originally submitted. The RCCO had the opportunity to receive technical assistance, incorporate HSAG's recommendations, and resubmit the PIP. After resubmission, the RCCO improved the overall validation score for its PIP from 75 percent to 88 percent and achieved a *Met* validation status.

Table 2–1—FY 2015–2016 Performance Improvement Project Validation Activity for Community Health Partnership—Region 7

Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay	Submission	75	100	*Partially Met*
	Resubmission	88	100	*Met*

[1] **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the RCCO was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Validation Findings

Table 2–2 displays the validation results for the **CHP** PIP validated during FY 2015–2016. This table illustrates the RCCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as

Met, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 2–2 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities. This was the second validation year for the PIP, with the RCCO completing Activities I through VIII. As the PIP progresses, the RCCO will report Remeasurement 1data for calendar year 2015.

Table 2–2—Performance Improvement Project Validation Results for Community Health Partnership—Region 7

Stage	Activity		Percentage of Applicable Elements		
			Met	***Partially Met***	***Not Met***
Design	I.	Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Review the Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Review the Selected Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI.	Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII.	Review the Data Analysis and Interpretation of Results	67% (2/3)	33% (1/3)	0% (0/3)
	VIII.	Assess the Improvement Strategies	75% (3/4)	25% (1/4)	0% (0/4)
Implementation Total			**71% (5/7)**	**29% (2/7)**	**0% (0/7)**
Outcomes	IX.	Assess for Real Improvement Achieved	*Not Assessed*		
	X.	Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*			**88% (14/16)**	**13% (2/16)**	**0% (0/16)**

Overall, 88 percent of all applicable evaluation elements validated received a score of *Met*.

Design

CHP designed a scientifically sound project supported by the use of key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Implementation

CHP reported its baseline study indicator results accurately in the study indicator data table; however, the narrative interpretation of study indicator results did not align with the baseline results reported in the data table. The RCCO used appropriate quality improvement tools to conduct its causal/barrier analysis, but some of the information included in the PIP's barriers and interventions table was unclear. For example, the priority rankings listed in the barriers and interventions table did not align and were not consistent with the barrier rankings documented in the RCCO's failure modes and effects analysis (FMEA) ranking. Additionally, the intent of one of the interventions listed in the barriers and interventions table was unclear based on the intervention description provided. In general, however, the interventions implemented during the baseline measurement period were logically linked to the study indicator, were implemented in a timely manner, and were likely to impact the study indicator outcomes. The RCCO did not progress to the point of evaluating intervention effectiveness during the baseline measurement period.

Outcomes

The PIP had not progressed to the Outcomes stage during this validation cycle.

Analysis of Results

Table 2–3 displays baseline data for **CHP**'s ***Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay*** PIP. **CHP** set a Remeasurement 1 goal to reduce the 90-day all-cause hospital readmission rate by 3 percentage points.

Table 2–3—Performance Improvement Project Outcomes for Community Health Partnership—Region 7

Study Indicator	Baseline Period (7/1/2014–6/30/2015)	Remeasurement 1 (7/1/2015–6/30/2016)	Remeasurement 2 (7/1/2016–6/30/2017)	Sustained Improvement
The rate of all-cause readmissions within 90 days of hospital discharge to a 14-day medical respite program among homeless members.	32.4%			

The baseline 90-day all-cause readmission rate for homeless members who were discharged from a hospital inpatient stay to a medical respite program was 32.4 percent. The RCCO set a goal for the Remeasurement 1 period to decrease the readmission rate by 3 percentage points.

Barriers/Interventions

The identification of barriers through causal barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The RCCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to overall success in improving PIP outcomes.

For the ***Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay*** PIP, **CHP** identified several categories of barriers related to reducing readmissions for homeless members. The RCCO used a fishbone diagram and failure modes and effects analysis (FMEA) to explore barriers related to reducing readmissions among homeless members. Identified barriers included members' lack of a place to stay during post-discharge recovery, lack of a primary care manager to facilitate wraparound care after discharge, and an increase in members with behavioral healthcare needs. To address these barriers, **CHP** implemented the following interventions:

- Contracted with Ascending to Health Respite Care (ATHRC) to provide a 14-day respite care stay to RCCO homeless members discharged from an inpatient hospital stay.
- Identified a primary care manager for each eligible member and established a health team with other clinicians.
- Began working to integrate behavioral health services into ATHRC's model of care by collaborating with community behavioral health providers.

Conclusions

CHP designed a methodologically sound project. The sound PIP study design allowed the RCCO to progress to baseline data collection and intervention development. The RCCO accurately reported the baseline study indicator results in the study indicator results table; however, the narrative interpretation of the baseline study indicator results did not align with the results in the table. For the baseline causal/barrier analysis process, the RCCO used a fishbone diagram and failure modes and effects analysis (FMEA) to identify and prioritize barriers to improvement; however, some of the barrier and intervention documentation in the PIP Summary Form was unclear. The RCCO implemented logical and timely interventions and described plans and next steps for the PIP's improvement strategies.

Recommendations

As the PIP progresses, HSAG recommends that the health plan:

- Update the documentation of the Remeasurement 1 goal for the study indicator rate so that the baseline rate, the Remeasurement 1 goal, and the documented percentage point difference between the baseline rate and the Remeasurement 1 goal are aligned.
- Update the narrative interpretation of the baseline study indicator results to align with the baseline study indicator results reported in the Activity VII data table.
- Clarify the relationship between the priority rankings documented in the FMEA and the rankings documented in the barrier and interventions table in Activity VIII of the PIP Summary Form. The documentation should demonstrate how the FMEA was used to rank the barriers in order of priority.
- Ensure that all implemented interventions are clearly and accurately described in the Activity VIII barriers and interventions table. The health plan should revise the intervention listed as "Member Health Assessment will be imperative to assessing the next steps in the member's care continuum" so that a clear description of the intervention is documented.
- Seek technical assistance from HSAG as needed.

The following contains the PIP-specific validation tool for **CHP**.

Appendix A: Colorado FY 15-16 PIP Validation Tool: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay for Community Health Partnership - Region 7

DEMOGRAPHIC INFORMATION

Plan Name:	Community Health Partnership - Region 7		
Project Leader Name:	Amy Harder	Title:	Community Strategies Director
Telephone Number:	(719) 632-5094	E-mail Address:	amy.harder@ppchp.org
Name of Project/Study:	Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay		

Type of Project (for HSAG's internal tracking):

☑ Clinical ☐ Nonclinical

☐ Collaborative ☐ HEDIS

Date of Project: 7/1/2014 to 6/30/2015

Type of Delivery System: RCCO

Submission Date: 1/14/2016

Section to be completed by HSAG

11/11/2014	Year 1 Validation	11/6/2014	Resubmission
11/11/2015	Year 2 Validation	10/29/2015	Annual Submission
1/25/2016	Year 2 Validation	1/14/2016	Resubmission

X Pre-Baseline

X Remeasurement 1

Year 1 validated through Activity: VI

Year 2 validated through Activity: IX

Appendix A: Colorado FY 15-16 PIP Validation Tool: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay for Community Health Partnership - Region 7

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
I.	**Select the Study Topic: The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State. The study topic:**		
C*	1. Is selected following collection and analysis of data. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Selection of the PIP topic followed the collection and analysis of data specific to the health plan.
	2. Has the potential to affect member health, functional status, or satisfaction. The score for this element will be Met or Not Met.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The PIP has the potential to affect member health, functional status, or satisfaction.

Results for Activity I

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
2	2	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. States the problem to be studied in simple terms and is in the recommended X/Y format. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study question was clear and stated in simple terms using the recommended X/Y format.

Results for Activity II

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
1	1	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special health care needs. The study population:**		
C*	1. Is accurately and completely defined and captures all members to whom the study question(s) applies. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan accurately and completely defined the study population, providing correct codes for the denominator, when applicable.

Results for Activity III

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
1	1	0	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound. The study indicator(s):**		
C*	1. Are well-defined, objective, and measure changes in health or functional status, member satisfaction, or valid process alternatives.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The study indicator was objective, clear, and unambiguously defined. The health plan provided correct codes, when applicable, for the numerator. The documentation provided a description of the study indicator, as well as the definition for the numerator and denominator. Re-review January 2016: In the resubmission, the health plan revised the measurement periods as recommended; however, the Remeasurement 1 time frame was incorrect and should be July 1, 2015, through June 30, 2016—not what is currently documented. Also, the Remeasurement 2 time frame should be included in the table and follow the date range accordingly. The original *Point of Clarification* was removed.
	2. Include the basis on which the indicator(s) was adopted, if internally developed.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan provided the rationale and basis for which the study indicator was developed.

Results for Activity IV

# of Total Evaluation Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
2	2	0	0	0

# of Critical Elements				
Critical Elements***	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
1	1	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

	EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
V.	**Use Sound Sampling Techniques: (If sampling is not used, each evaluation element is scored NA.) If sampling is used to select members in the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Include the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1, etc.).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
	2. Include the title of the applicable study indicator(s).	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
	3. Identify the population size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
C*	4. Identify the sample size.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
	5. Specify the margin of error and confidence level.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
	6. Describe in detail the methods used to select the sample.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.
C*	7. Allow for the generalization of results to the study population.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	Sampling techniques were not used in this PIP.

Results for Activity V

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
7	0	0	0	7	2	0	0	0	2

* "C" in this column denotes a critical evaluation element.
** Total Evaluation Elements includes critical elements.
*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VI.	**Reliably Collect Data: Data collection must ensure that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements to be collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The documentation included the identification of data elements and data sources used for collection.
C*	2. Clearly defined and systematic process for collecting data that includes how baseline and remeasurement data will be collected. NA is not applicable to this element for scoring.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan specified a systematic method for collecting baseline and remeasurement data.
C*	3. A manual data collection tool that ensures consistent and accurate collection of data according to indicator specifications.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The health plan did not use manual data collection.
	4. An estimated degree of administrative data completeness. Met = 80 - 100 percent Partially Met = 50 - 79 percent Not Met = <50 percent or not provided	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The estimated degree of administrative data completeness was between 80 percent and 100 percent, and the documentation included how the health plan determined the reported percentage of 100 percent.

Results for Activity VI

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
4	3	0	0	1	2	1	0	0	1

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VII.	**Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Include accurate, clear, consistent, and easily understood information in the data table.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan presented results in a clear, accurate, and easily understood format. Re-review January 2016: In the resubmission, the health plan revised its measurement periods in the data table; however, it needs to update the goal percentage. Decreasing the readmission rate by 3 percentage points does not equal 18.7 percent with the new, updated baseline rate. The health plan will need to make sure all updates are completed prior to the next annual submission.

* "C" in this column denotes a critical evaluation element.
** Total Evaluation Elements includes critical elements.
*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
VII. **Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
2. Include a narrative interpretation that addresses all required components of data analysis and statistical testing.	☐ Met ☑ Partially Met ☐ Not Met ☐ NA	The health plans interpretation did not include statistical testing between baseline and Remeasurement 1. The health plan must conduct statistical testing between baseline and the first remeasurement, report the *p* value, document the type of two-tailed test used, and include a narrative regarding the statistical findings. Lastly, the health plan documented an 11 percentage point difference between baseline and Remeasurement 1. The correct difference is 10.7 percentage points. If the health plan revises its measurement periods as outlined in Activity IVs comment, statistical testing will no longer be required if only baseline data are reported. Re-review January 2016: In the resubmission, the health plan did not update its interpretation of the baseline results based on the new, updated data reported with revised measurement period dates. The score for this evaluation element will remain *Partially Met*. The health plan will need to ensure that all updates are completed prior to the next annual submission.

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
VII. **Analyze Data and Interpret Study Results: Clearly present the results for each study indicator(s). Describe the data analysis performed and the results of the statistical analysis, if applicable, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined. The data analysis and interpretation of the study indicator outcomes:**		
3. Identify factors that threaten the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan identified that no identified factors threatened the internal or external validity of the data reported or the ability to compare the baseline against the goal or benchmark, but the comparison should be made to the first remeasurement results. The health plan needs to correct its documentation. Re-review January 2016: In the resubmission, the health plan revised its measurement periods and reported baseline rate. The narrative regarding factors that threaten the validity of the data reported and the ability to compare the initial remeasurement with the remeasurement is applicable because of these revisions. For this reason, the score for this evaluation element has been changed to *Met.*

Results for Activity VII

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
3	2	1	0	0	1	1	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of each intervention. The improvement strategies are developed from an ongoing quality improvement process that includes:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The health plan completed a causal/barrier analysis and used improvement strategies related to the causes/barriers identified through data analysis and a quality improvement process. Re-review January 2016: In the resubmission attachments, the health plan corrected the title of the fishbone diagram as recommended. The original *Point of Clarification* was removed.

* "C" in this column denotes a critical evaluation element.
** Total Evaluation Elements includes critical elements.
*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		
VIII. **Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of each intervention. The improvement strategies are developed from an ongoing quality improvement process that includes:**		
2. Barriers that are identified and prioritized based on results of data analysis and/or other quality improvement processes.	☐ Met ☑ Partially Met ☐ Not Met ☐ NA	The barriers were prioritized using a failure modes and effects analysis (FMEA); however, not all barriers were listed in the barrier/intervention table with their corresponding rankings. The FMEA had a few failure modes with the same numerical value of 125, but only one barrier and one intervention were listed in the barrier/intervention table. The narrative section of Activity VIII provided some insight as to the "whys," but the intervention of assigning members to a primary care manager and the "Member Health Assessment" intervention were also not listed in the barrier/intervention table. Lastly, several barriers were identified on the fishbone; but no explanation was provided as to why only one barrier and one intervention were listed in Activity VIII in the table. The PIP Summary Form content and attachments did not align. Re-review January 2016: In the resubmission, the health plan addressed some of HSAG's feedback but not all. For example, new interventions were added to the Intervention/Barrier table but the priority ranking of 100 did not align with the attached FMEA ranking. In addition, the health plan's system intervention implemented in December 2015 stated " Member Health Assessment will be imperative to assessing the next steps in the member's care continuum." HSAG is unclear as to what the actual intervention is. Did the health plan implement a member health assement process? Further documentation is required to meet the validation criteria. The score will remain *Partially Met*.

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
VIII.	**Improvement Strategies (interventions for improvement as a result of analysis): Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of each intervention. The improvement strategies are developed from an ongoing quality improvement process that includes:**		
C*	3. Interventions that are logically linked to identified barriers and will directly impact study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	The sole intervention mentioned was logically linked to the only barrier listed in the barrier/intervention table. Re-review January 2016: The health plan addressed the *Point of Clarification* in the resubmission; therefore it has been removed.
	4. Interventions that were implemented in a timely manner to allow for impact of study indicator outcomes.	☑ Met ☐ Partially Met ☐ Not Met ☐ NA	Based on the limited intervention provided in the barrier/intervention table, HSAG could not determine if all quality improvement efforts being conducted by the health plan were implemented in a timely manner to allow sufficient time to have a positive impact on the outcomes. Re-review January 2016: In the resubmission, the health plan revised its documentation by adding interventions and date of implementation. The date of implementation allowed for impact to the study indicator outcomes. The score for this evaluation element has been changed to *Met*.
C*	5. Evaluation of individual interventions for effectiveness.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIP has not progressed to the point of evaluating the effectiveness of each intervention.
	6. Interventions continued, revised, or discontinued based on evaluation results.	☐ Met ☐ Partially Met ☐ Not Met ☑ NA	The PIP has not progressed to the point of evaluating the interventions.

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS	SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation		

Results for Activity VIII

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
6	3	1	0	2	3	2	0	0	1

* "C" in this column denotes a critical evaluation element.
** Total Evaluation Elements includes critical elements.
*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology is the same as the baseline methodology.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not assessed. The PIP had not progressed to the point of being assessed for real improvement.
C*	2. The documented improvement meets the State- or health plan-specific goal.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not assessed. The PIP had not progressed to the point of being assessed for real improvement.
C*	3. There is statistically significant improvement over baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not assessed. The PIP had not progressed to the point of being assessed for real improvement.

Results for Activity IX

# of Total Evaluation Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
3	0	0	0	0

# of Critical Elements				
Critical Elements***	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
2	0	0	0	0

* "C" in this column denotes a critical evaluation element.

** Total Evaluation Elements includes critical elements.

*** This number is a tally of the total number of critical evaluation elements for this review activity.

EVALUATION ELEMENTS		SCORING	COMMENTS
Performance Improvement Project/Health Care Study Evaluation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrate sustained improvement over baseline.	☐ Met ☐ Partially Met ☐ Not Met ☐ NA	Not assessed. Sustained improvement cannot be assessed until the study indicator has achieved statistically significant improvement over baseline and sustained the improvement for a subsequent measurement period.

Results for Activity X

# of Total Evaluation Elements					# of Critical Elements				
Total Evaluation Elements**	**Met**	**Partially Met**	**Not Met**	**Not Applicable**	**Critical Elements*****	**Met**	**Partially Met**	**Not Met**	**Not Applicable**
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a critical evaluation element.
** Total Evaluation Elements includes critical elements.
*** This number is a tally of the total number of critical evaluation elements for this review activity.

Appendix A: Colorado FY 15-16 PIP Validation Tool: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay for Community Health Partnership - Region 7

Table A-1—FY 15-16 PIP Validation Report Scores: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay for Community Health Partnership - Region 7

	Review Activity	Total Possible Evaluation Elements (Including Critical Elements)	Total Met	Total Partially Met	Total Not Met	Total NA	Total Possible Critical Elements	Total Critical Elements Met	Total Critical Elements Partially Met	Total Critical Elements Not Met	Total Critical Elements NA
I.	Select the Study Topic	2	2	0	0	0	1	1	0	0	0
II.	Define the Study Question(s)	1	1	0	0	0	1	1	0	0	0
III.	Define the Study Population	1	1	0	0	0	1	1	0	0	0
IV.	Select the Study Indicator(s)	2	2	0	0	0	1	1	0	0	0
V.	Use Sound Sampling Techniques	7	0	0	0	7	2	0	0	0	2
VI.	Reliably Collect Data	4	3	0	0	1	2	1	0	0	1
VII.	Analyze Data and Interpret Study Results	3	2	1	0	0	1	1	0	0	0
VIII.	Improvement Strategies (interventions for improvement as a result of analysis)	6	3	1	0	2	3	2	0	0	1
IX.	Assess for Real Improvement	3		Not Assessed			2	Not Assessed			
X.	Assess for Sustained Improvement	1		Not Assessed			1	Not Assessed			
Totals for All Activities		**30**	**14**	**2**	**0**	**10**	**15**	**8**	**0**	**0**	**4**

Table A-2—FY 15-16 PIP Validation Report Overall Scores: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay for Community Health Partnership - Region 7

Percentage Score of Evaluation Elements Met*	**88%**
Percentage Score of Critical Elements Met**	**100%**
Validation Status***	***Met***

* The percentage score is calculated by dividing the total Met by the sum of the total Met, Partially Met, and Not Met.

** The percentage score of critical elements Met is calculated by dividing the total critical elements Met by the sum of the critical elements Met, Partially Met, and Not Met.

*** Met equals confidence/high confidence that the PIP was valid.
Partially Met equals low confidence that the PIP was valid.
Not Met equals reported PIP results that were not credible.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

HSAG assessed the implications of the study's findings on the likely validity and reliability of the results based on CMS Validating protocols. HSAG also assessed whether the State should have confidence in the reported PIP findings.

***Met* = Confidence/high confidence in reported PIP results**

****Partially Met* = Low confidence in reported PIP results**

*****Not Met* = Reported PIP results not credible**

Summary of Aggregate Validation Findings

*	X	*Met*	**		*Partially Met*
***		*Not Met*			

Summary statement on the validation findings:

Activities I through VIII were assessed for this PIP Validation Report. Based on the validation of this PIP, HSAG's assessment determined confidence in the results.

The following contains the PIP-specific summary form for **CHP**.

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCCO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

DEMOGRAPHIC INFORMATION	
Plan Name: **Community Care of Central Colorado (RCCO 7)**	
Project Leader Name: Amy Harder Title: Community Strategies Director	
Telephone Number: 719-632-5094 E-mail Address: amy.harder@ppchp.org	
Name of Project: Medical respite care for homeless RCCO members discharged from hospital inpatient stay	
Type of Project (for HSAG's internal tracking): ☐ Clinical ☒ Nonclinical ☒ Collaborative ☐ HEDIS	**Section to be completed by HSAG** _____ Year 1 Validation _____ Initial Submission __X__ Year 2 Validation 10/22/15 Initial Submission _____ Year 3 Validation _____ Initial Submission
Type of Delivery System: RCCO	__X__ Baseline Assessment _____ Remeasurement 1 _____Remeasurement 2 _____ Remeasurement 3
Submission Date: November 5, 2014 (Rev 1)	Year 1 validated through Activity VI Year 2 validated through Activity VIII Year 3 validated through Activity_____

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State.

Study Topic: The Department of Health Care Policy and Financing has selected transitions of care as a statewide performance improvement plan topic. RCCO 7 is choosing to focus its performance improvement project on care transitions for homeless members discharged from inpatient hospital stays.

Provide health plan-specific data: Community Care selects this topic because the 90-day all-cause readmission percentage for homeless RCCO members is nearly double the all-cause readmission percentage general RCCO population. Community Care analyzed claims data from the June 2014 statewide data analytics contractor (SDAC) All Members Report for 398 homeless RCCO members and determined that 46 homeless members had inpatient stays in the preceding 12 months. Of those 46 members, 10 (21.74%) members had a readmission within 90 days. For the RCCO general population there were 4,161 inpatient admissions during the same timeframe and 465 90-day readmissions, or an 11.18% readmission percentage.

Describe how the study topic has the potential to improve member health, functional status, or satisfaction: Hospital readmission rates can be an indicator of poor quality care and/or poor quality care transitions. Patients transitioning from hospital to home are at risk for poor health outcomes if the care transition is not properly planned, if follow-up care is not arranged prior to discharge, if the patient has complex medical or behavioral health issues, and if the patient does not have financial or social support resources to support post-hospital recuperation. Homeless patients are at higher risk for poor health outcomes and hospital readmissions because homeless patients experience a higher incidence of complex and chronic health conditions, do not have a safe place to recover post-discharge, and lack financial resources to support post-discharge needs.[1] [2]

Studies show that providing medical respite care for homeless patients can reduce 90-day readmission rates as well as reduce the number of inpatient days in the 12 month period post-respite stay.[3] [4] The use of 90-day readmissions has been previously used in several key studies on medical respite care for the homeless and established as a timeframe appropriate for judging the adequacy of discharge planning.[5] [6] This timeframe also allows for patient variations in post-

[1] Burt M, et al. *Homelessness: programs and the people they serve: findings of the National Survey of Homeless Assistance Providers and Clients*. Prepared for the Interagency Council on the Homeless. Dec 1999.
[2] Levy BD and O'Connell JJ. *Health care for homeless persons*. N Engl J of Med 2004; 350(23):23292332.

[3] Kettesz SG, et al. *Post-hospital medical respite care and hospital readmission of homeless persons*. J Prev Interv Community, 2009; 37(2): 129-142.
[4] Buchanan D, et al. *The effects of respite care for homeless patients: a cohort study*. Amer J of Public H, 2006; 96(7):1278-1281.
[5] Kertesz SG, Posner M A, O'Connell JJ, et al. Post-hospital medical respite care and hospital readmission of homeless persons. J Prev Interv Community, 2009; 37(2): 129-142.
[6] Bauer J, Moughamian A, Viloria J, Schneidermann M. Leaving before discharge from a homeless medical respite program: Predisposing factors and impact on selected outcomes. J Health Care Poor Underserved, 2012; 23(3): 1092-105.

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity I: Select the Study Topic. The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of health care. The topic may be specified by the State.
onsite respite care. Once patients physically leave the respite care site, they may still receive assistance for up to 45 days from respite program staff with such issues as transportation to medical appointments and housing procurement

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity II: Define the Study Question(s). Stating the question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation.

The Study Question(s) should:

- Be structured in the recommended X/Y format: "Does doing X result in Y?"
- State the problem in clear and simple terms.
- Be answerable based on the data collection methodology and study indicator(s) provided.

Study Question(s):

Does providing 14-day medical respite care to homeless RCCO Medicaid clients decrease the percentage of all-cause readmissions within 90 days of inpatient discharge?

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special health care needs.

The study population definition should:

- Include the requirements for the length of enrollment, defining continuous enrollment, new enrollment, and allowable gaps in enrollment.
- Include the complete age range of the study population and the anchor dates used to identify age criteria, if applicable.
- Clearly define the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify members, if applicable.
- Capture all members to whom the study question(s) applies.
- Include how race/ethnicity will be identified, if applicable.

Study Population: Homeless RCCO members with an inpatient hospital stay who are discharged to a medical respite care program. While it is impossible to measure with complete accuracy the number of homeless people in a community, Pikes Peak United Way estimated that as of January 2013 there were approximately 1,800 homeless people living in Colorado Springs. With Medicaid expansion effective January 1, 2014 and mandatory passive enrollment of the expansion population into the RCCO program, approximately 73% of the expansion population in Region 7 has been enrolled in Community Care as of July 1, 2014. This could translate to Community Care having roughly 1,314 homeless members in its population. Unfortunately, there is not an alert in Medicaid when a member is homeless. Community Care must rely on self-reporting of homelessness status by members to hospital discharge planners or to the member's primary care medical provider (PCMP). In the case where a homeless member is served by Peak Vista Community Health Centers, which has a homeless clinic, Peak Vista has a flag in the patient record to indicate homeless status. Peak Vista provides to the RCCO the Medicaid numbers and names of patients in the RCCO flagged as homeless in their medical records. As described above there were 398 members flagged as homeless at Peak Vista as of June 30, 2014.

Enrollment requirements (if applicable): Members must have an open Medicaid or RCCO enrollment span at time of hospital discharge. Members should be enrolled for at least 90 days following the inpatient discharge. Members who disenroll from the RCCO prior to the 90 days should be excluded from the study population (denominator). Exclusion will be determined on a case by case basis as changes in enrollment status in Medicaid or RCCO will not automatically exclude a patient. Patients that lose Medicaid eligibility or disenroll from RCCO 7 post discharge from medical respite care will not automatically be excluded from numerator or denominator because respite care program follows its patients and can provide readmission information for the study if a member were to disenroll from the RCCO program or lose Medicaid eligibility.

Member age criteria (if applicable): Adults age 18 and older are eligible for the study. Date of birth in Medicaid record and in hospital discharge form will be used to verify age.

Inclusion, exclusion, and diagnosis criteria: All adults that identify as permanent or temporary homeless or who do not have a safe, stable place to recover post-hospital discharge are eligible. Exclusions to the study include members discharged to medical respite care by the hospital but fail to be admitted into respite

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity III: Define the Study Population. The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special health care needs.

The study population definition should:

- Include the requirements for the length of enrollment, defining continuous enrollment, new enrollment, and allowable gaps in enrollment.
- Include the complete age range of the study population and the anchor dates used to identify age criteria, if applicable.
- Clearly define the inclusion, exclusion, and diagnosis criteria.
- Include a list of diagnosis/procedure/pharmacy/billing codes used to identify members, if applicable.
- Capture all members to whom the study question(s) applies.
- Include how race/ethnicity will be identified, if applicable.

care within 12 hours of discharge due to the following reasons: level of medical care required exceeds level of care allowable in medical respite program or member does not wish to voluntarily enroll once onsite.

Diagnosis/procedure/pharmacy/billing codes (if applicable): Community Care will use the following CPT codes to determine when a study patient has been admitted to the hospital: Initial hospital visits (99221-99223); Subsequent hospital visits (99231-99233); Critical Care services (99291-99292).

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include complete descriptions of the numerators and denominators, defining the terms used.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include health plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Study Indicator 1: Enter title of study indicator	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.**
Numerator: (no numeric value)	Number of RCCO homeless members with a hospital all-cause readmission within 90 days post-discharge from inpatient stay where discharge disposition was to medical respite program during the measurement period using CPT codes: Initial hospital visits (99221-99223); Subsequent hospital visits (99231-99233); Critical Care services (99291-99292).
Denominator: (no numeric value)	Number of RCCO homeless members discharged from inpatient stay where discharge disposition was to medical respite program during measurement period
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	07/01/14 to 06/30/15
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	07/01/16 to 06/30/17
Remeasurement 1 Period Goal	Reduce readmission rate by 3% from measurement period actual measurement

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include complete descriptions of the numerators and denominators, defining the terms used.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include health plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	The Department has not set a goal or benchmark for this project. Healthy Transitions Colorado has set a goal to reduce all-cause 30-day readmissions throughout Colorado by 8,700. Healthy Transitions lists the percentage of 30 day readmissions for commercial and Medicaid insured lives as 9.5%. The percentage for Medicare covered lives is 15.7%. The goal of Healthy Transitions Colorado is to reduce these percentages and improve health. RCCO 7 is a member of the Healthy Transitions collaboration.
Source of Benchmark	http://healthy-transitions-colorado.org/progress/metrics-dashboard/
Study Indicator 2: Enter title of study indicator	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on which the indicator was adopted, if internally developed.**
Numerator: (no numeric value)	
Denominator: (no numeric value)	

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include complete descriptions of the numerators and denominators, defining the terms used.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include health plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	
State-Designated Goal or Benchmark	
Source of Benchmark	
Study Indicator 3: Enter title of study	**Provide a narrative description and the rationale for selection of the study indicator. Describe the basis on**

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include complete descriptions of the numerators and denominators, defining the terms used.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include health plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

indicator	**which the indicator was adopted, if internally developed.**
Numerator: (no numeric value)	
Denominator: (no numeric value)	
Baseline Measurement Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 1 Period Goal	
Remeasurement 2 Period (include date range) MM/DD/YYYY to MM/DD/YYYY	
Remeasurement 2 Period Goal	

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity IV: Select the Study Indicator(s). A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Study indicator goals should be specific, measurable, attainable, relevant, and time-bound.

The description of the study Indicator(s) should:

- Include the complete title of the study indicator(s).
- Include complete descriptions of the numerators and denominators, defining the terms used.
- Include the rationale for selecting the study indicator(s).
- If indicators are based on nationally recognized measures (e.g., HEDIS), include the year of the HEDIS technical specifications used for the applicable measurement year and update the year annually, as appropriate.
- Include complete dates for all measurement periods (with the day, month, and year).
- Include health plan-specific goals for the remeasurement periods that are specific, measurable, attainable, relevant, and time-bound.
- Include the State-designated goal, if applicable.

State-Designated Goal or Benchmark	
Source of Benchmark	
Use this area to provide additional information. Discuss the guidelines and basis for each study indicator.	

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity V: Use Sound Sampling Techniques. If sampling is to be used to select members of the study, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling techniques should be in accordance with generally accepted principles of research design and statistical analysis. Representative sampling techniques should be used to ensure generalizable information**.**

The description of the sampling methods should:

- Include components identified in the table below.
- Be updated annually for each measurement period and for each study indicator.
- Include a detailed narrative description of the methods used to select the sample; ensure sampling techniques support generalizable results.

Measurement Period	Study Indicator	Population Size	Sample Size	Margin of Error and Confidence Level
MM/DD/YYYY–MM/DD/YYYY				

Describe in detail the methods used to select the sample: N/A

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VI: Reliably Collect Data. Data collection must ensure that data collected on study indicators are valid and reliable.

Data collection methodology should include the following:

- Identification of data elements and data sources.
- When and how data are collected.
- How data are used to calculate the study indicators.
- A copy of the manual data collection tool, if applicable.
- An estimate of administrative data completeness and the process used to determine completeness.

Data Sources (Select all that apply)

[ ] Hybrid—Both medical/treatment records (manual data collection) and administrative data collection processes are used

[ ] Medical/Treatment Record Abstraction
Record Type
[ ] Outpatient
[ ] Inpatient
[ ] Other
_____

Other Requirements
[ ] Data collection tool attached
[ ] Other Data
_____

[ ] Administrative Data
Data Source
[x] Programmed pull from claims/encounters
[ ] Complaint/appeal
[ ] Pharmacy data
[ ] Telephone service data/call center data
[ ] Appointment/access data
[ ] Delegated entity/vendor data _____
[x] Other _____

Other Requirements
[x] Codes used to identify data elements (e.g., ICD-9/ICD-10, CPT codes) CPT codes: Initial hospital visits (99221-99223); Subsequent hospital visits (99231-99233); Critical Care services (99291-99292)
_____
[ ] Data completeness assessment attached
[ ] Coding verification process attached

Estimated percentage of administrative data completeness: _____ percent.

Describe the process used to determine data completeness:
The data collection process will use a combination of SDAC data reports for claims, SDAC patient profile data, and monthly hospital

[ ] Survey Data
Fielding Method
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Other
_____

Other Requirements
[ ] Number of waves _____
[ ] Response rate _____
[ ] Incentives used _____

Activity VI: Reliably Collect Data. Data collection must ensure that data collected on study indicators are valid and reliable. **Data collection methodology should include the following:** ◆ Identification of data elements and data sources. ◆ When and how data are collected. ◆ How data are used to calculate the study indicators. ◆ A copy of the manual data collection tool, if applicable. ◆ An estimate of administrative data completeness and the process used to determine completeness.		
	discharge reports from Memorial Hospital and Penrose Hospitals in Colorado Springs. Medicaid claims data has a four month lag in the SDAC and hospitals can bill for services up to one year after date of service. Hospital admission, discharge, and transfer reports provided to the RCCO by two area hospitals are provided monthly to the RCCO. Patients admitted to the medical care respite program will have claims monitored for at least four months post discharge. Patients discharged from a hospital after March 30 will have data monitored four months post discharge to allow for claims run out.	

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VI: Determine the Data Collection Cycle.	Determine the Data Analysis Cycle.
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [x] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): Data will be collected monthly from Ascending to Health Respite Care regarding patients enrolled in respite care, services provided and disposition at discharge. SDAC claims data and eligibility data is refreshed monthly by the state. Hospital admission, discharge and transfer data is provided daily to the RCCO with a monthly reconciliation report. The monthly reconciliation report will be used to determine discharge disposition to medical respite care or to other locations. We estimate 100% data completeness for this project. If a member loses eligibility in the study timeframe, respite care continues to follow the patient and can provide data regarding 90-day readmissions.	[ ] Once a year [ ] Once a season [x] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): Data will be analyzed quarterly from the earlier referenced data sources. Data will be reviewed for completeness every quarter to allow for claims run out. The study indicator will be calculated using number of members with inpatient admits who are discharged calculated from hospital data and SDAC data for identified homeless patients (denominator). Patients discharged to medical respite care that have an all-cause readmission within 90 days to a hospital will be the numerator.

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Describe the data collection process:
There is no Medicaid identifier in SDAC data reports to indicate homeless status. Community Care must rely on self-reporting of homelessness status by members to hospital discharge planners or to the member's PCMP. In the case where a homeless member is served by Peak Vista Community Health Centers, which has a homeless clinic, Peak Vista has a flag in the patient record to indicate homeless status. Peak Vista provides quarterly to RCCO 7 the Medicaid IDs of patients in the RCCO flagged as homeless in their medical records. There were 398 members flagged as homeless at Peak Vista as of June 30, 2014. Peak Vista is Community Care's largest single PCMP with 46,107 (or 42.1%) unique clients attributed. Peak Vista can update quarterly the Medicaid IDs of those flagged as homeless. These Medicaid IDs are analyzed against the SDAC data reports to collect the information needed regarding the patient's demographic and medical history. SDAC data reports are refreshed monthly. Data will be collected monthly from Ascending to Health Respite Care regarding homeless patients enrolled in respite care, the services provided by Ascending to Health Respite Care, and disposition at discharge. Those discharged from this respite care are tracked for a period of time and this information will also be available to RCCO 7 on a monthly basis. Hospital admission, discharge and transfer data is provided daily to RCCO 7. RCCO 7 will also be provided with a monthly hospital admission, discharge and transfer data reconciliation report. The monthly reconciliation report will be used to determine discharge disposition to medical respite care or to other locations. We estimate 100% data completeness for this project. Aggregate and individual RCCO member data will be analyzed for evaluation of this project. Data elements pertinent to study analyses will be pulled for each RCCO 7 member receiving homeless respite care from the Ascending to Health Respite Care monthly reports and entered into an Excel spreadsheet for generating descriptive statistics and analyzing trends. Data elements used in quarterly analyses will include number of RCCO members enrolled in the respite care program, duration of onsite intervention, assistance provided by respite program staff post-discharge (from onsite intervention), housing status at time of respite care discharge, and specifics of the intervention per RCCO member, such as social services provided, and referrals (e.g., drug and alcohol counseling and mental health services). SDAC and hospital discharge data will be used to identify 30-day and 90-day hospital readmissions using CPT codes: Initial hospital visits (99221-99223); Subsequent hospital visits (99231-99233); Critical Care services (99291-99292).

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VII: Study Indicator Results. Clearly present the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the data reported in the validated performance measure rate(s).

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

Study Indicator 1 Title: Decreasing All-Cause 90-day Hospital Readmissions for Homeless RCCO 7 Members

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
07/01/2014-06/30/2015	**Baseline**	11	34	32.4%	Reduce 90-Day All-Cause Hospital Readmission rate by 3 percentage points to 18.74%	Not Applicable
	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

Study Indicator 2 Title: Enter title of study indicator

Time Period Measurement Covers	Indicator Measurement	Numerator	Denominator	Rate or Results	Goal	Statistical Test, Statistical Significance, and *p* Value
MM/DD/YYYY–MM/DD/YYYY	**Baseline**					

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VII: Study Indicator Results. Clearly present the results of the study indicator(s) in the table below. For HEDIS-based PIPs, the data reported in the PIP Summary Form should match the data reported in the validated performance measure rate(s).

Enter results for each study indicator—including the goals, statistical testing with complete *p* values, and the statistical significance—in the table provided.

	Remeasurement 1					
	Remeasurement 2					
	Remeasurement 3					

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VII: Data Analysis and Interpretation of Study Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data and results presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the findings to the goal and the type of statistical test completed, if applicable, with resulting *p* values calculated to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement that identifies any factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods. If no factors are identified, the lack of threats to validity and comparability should be clearly stated.

Describe the data analysis process and provide an interpretation of the results for each measurement period.

The study indicator rate was calculated using the number of RCCO 7 homeless members with a hospital all-cause readmission within 90-days post-discharge from inpatient stay where discharge disposition was to medical respite program during the evaluation period (numerator), divided by the number of RCCO homeless members discharged from inpatient stay where discharge disposition was to medical respite program during measurement period (denominator). The data source for hospital admission and re-admission was SDAC June 2014 raw claims using CPT codes: Initial hospital visits (99221-99223); Subsequent hospital visits (99231-99233); and Critical Care services (99291-99292). RCCO 7 had to rely on self-reporting of homelessness status by members to hospital discharge planners or to the member's primary care medical provider (PCMP). In the case where a homeless member is served by Peak Vista Community Health Centers, which has a homeless clinic, Peak Vista has a flag in the patient record to indicate homeless status. Peak Vista provided to the RCCO the Medicaid numbers and names of patients in the RCCO flagged as homeless in their medical records. There were 398 members flagged as homeless at Peak Vista as of June 30, 2014. Data was analyzed quarterly for completeness to allow for claims run out.

Baseline Measurement: RCCO 7 analyzed claims data from June 2014 SDAC raw claims data for 398 homeless RCCO members and determined that 46 homeless members had inpatient stays within the evaluation period. Of those 46 members, 10 (21.74%) members had an all-cause readmission within 90 days. For the RCCO general population there were 4,161 inpatient admissions during the same timeframe and 465 90-day readmissions, or an 11.18 percentage point readmission rate. The baseline measuring period was from 07/01/14 to 06/30/15. No factors were identified that threatened the validity of the baseline findings or that impacted the ability to compare the baseline results to the goal and benchmark.

Goal: The goal at baseline measurement was to reduce readmission percentage from 21.74% to 18.74%, which is a decrease in 3 percentage points.

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VII: Data Analysis and Interpretation of Study Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data and results presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the findings to the goal and the type of statistical test completed, if applicable, with resulting *p* values calculated to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement that identifies any factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods. If no factors are identified, the lack of threats to validity and comparability should be clearly stated.

Results: Preliminary analysis of the measurement period show an increase of 10.7 percentage points in 90-day readmission rates for this homeless population, whereas the 90-day readmission rate for the general population remains constant. As a result of transitioning care to medical respite care for homeless members, RCCO 7 saw that 11 patients who were readmitted after a respite stay of varying lengths and within 90 days of discharge all suffered from a serious condition prior to their respite stay (e.g., severe frost bite, gunshot wound, hit by a falling tree). All 11 patients who were readmitted after a respite stay and within 90 days of discharge have a risk category of complex chronic and also present with chronic behavioral health diagnoses. It is also important to note 6 of the 11 patients are currently seeking care for substance abuse. This revelation has helped RCCO 7 identify a possibility to narrow the scope of care on a patient-by-patient basis.

Lessons Learned: Although the number of all-cause 90-day readmits has not decreased as anticipated, RCCO 7 has learned that there may be room for amendments to the delivery of care given by Ascending to Health Respite Care (ATHRC). Many of the patients seen are diagnosed with complex chronic illnesses and also present with chronic behavioral health diagnoses which may affect the delivery of care and the methods of disease management by the patients themselves. This can help determine the specific activities that are needed in the delivery of care for particular diagnoses such as chronic depression, chronic personality disorder, or schizophrenia. In the remeasurement period to follow, RCCO 7 will study the length of stay and cost of stay for the all-cause 90-day readmits, this is in an effort to determine if there is a decrease in the cost and length of stay of the readmit after medical respite care in comparison to the cost and length of stay during the initial admission. RCCO 7 will also follow the patient after being discharged from Respite Care to ensure wrap-around services for the patient.

Baseline to Remeasurement 1:

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VII: Data Analysis and Interpretation of Study Results. Clearly present the results for each of the study indicator(s). Describe the data analysis performed and the results of the statistical analysis, and interpret the findings. Through data analysis and interpretation, real improvement as well as sustained improvement can be determined.

The data analysis and interpretation of study indicator results should include the following for each measurement period:

- Data and results presented clearly, accurately, and consistently in both table and narrative format.
- A clear and comprehensive narrative description of the data analysis process, including a comparison of the findings to the goal and the type of statistical test completed, if applicable, with resulting *p* values calculated to four decimal places (e.g., 0.0235).
- Discussion of any random, year-to-year variations; population changes; sampling errors; or statistically significant increases or decreases that occurred during the remeasurement process.
- A statement that identifies any factors that could threaten (a) the validity of the findings for each measurement period and/or (b) the comparability of measurement periods. If no factors are identified, the lack of threats to validity and comparability should be clearly stated.

Baseline to Remeasurement 2:

Baseline to Remeasurement 3:

Baseline to Final Remeasurement:

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

Activity VIII: Improvement Strategies (interventions for improvement as a result of analysis). Interventions are developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. Describe the barriers/interventions and provide quantitative details on the processes used to identify the barriers/interventions and to evaluate the effectiveness of each intervention. Do not include intervention planning activities.

This activity will include the following:

- Processes used to identify barriers/interventions.
- Prioritized list of barriers with corresponding interventions.
- Processes used to evaluate the effectiveness of the interventions and evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Please describe the process used to identify barriers and develop corresponding interventions. Include the team/committee/group that conducted the causal/barrier analysis and any QI tools that were used to identify barriers, such as data mining, fishbone diagram, process-level data, etc. Describe the process used to prioritize the barriers and designate high-priority barriers. Lastly, describe the process used to evaluate the effectiveness of each intervention. The documentation should be dated to identify when steps in the ongoing quality improvement process were visited/revisited.

A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools:

The process improvement team was selected based on the team members function within RCCO 7. Members of the team are outlined below in the Process Improvement Chart. As a team it was agreed that quarterly meetings are necessary, as the report deadline approached the team met on a weekly basis. The care coordination team agreed to meet monthly at the time that the Ascending to Health Respite Care monthly report is received. Fishbone Diagram and Process Mapping are the Lean Six Sigma techniques that we decided to utilize to assist us with process improvement.

Internal Team Members		
Project Role	**Name**	**Title**
PIP Owner	Amy Harder	Community Strategies Director
PIP Lead	Henry Lewis	Quality Improvement Manager
Executive Lead	Janet Winger	Chief Financial Officer
Care Coordination Lead	Joe Farr	Integrated Care Manager

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

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- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

Care Coordination Support	Pamela Burgoa	Care Coordinator
Analytical Lead	Helen Harris	Healthcare Data Manager
Analytical Support	Amy Vargo	Healthcare Data Analyst
Reporting Lead	Lisa Robinson-Kerr	Reporting and Evaluation Specialist
External Partner		
Project Role	**Name**	**Title**
Ascending to Health Respite	Gregory Morris	President and Founder

Quality improvement processes, tools, and/or data analysis results used to identify and prioritized barriers:

The Performance Improvement Plan (PIP) team worked together to identify opportunities for improvement. The PIP team utilized tools including a Member Flow Map, Fishbone Diagram, and Failure Modes and Effects Analysis chart to facilitate this process and to help identify and rank barriers. A member flow mapping session focused on the referral process from hospital inpatient stay to admission into the Ascending to Health Respite Care program. In conducting the member flow mapping session numerous barriers emerged. Identified barriers were prioritized and placed within a fishbone diagram. Each of the barriers was placed into the Failure Modes and Effects Analysis chart. Barriers such as the influx into the community of the homeless population during the summer months were not placed into the Failure Modes and Effects Analysis chart because of the limited opportunities for impactful intervention. Once the barriers were defined, brainstormed and placed into the Failure Modes and Effects Analysis chart each barrier was ranked by the team according to the method described in the chart. Behavioral health issues and treatment pertaining to pre-existing conditions were identified as the primary barriers to achieving the goal of the study indicator

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

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rate. Substance abuse was also identified as a barrier. A copy of the member flow map, fishbone diagram, and Failure Modes and Effects Analysis chart are attached.

Processes and measures used to evaluate the effectiveness of each intervention:

Effective January 1st 2014, the RCCO contracted with Ascending to Health Respite Care, Inc. (ATHRC) to allow for the enrollment of homeless or at-risk for homeless RCCO members into recuperative care services post-discharge from an emergency department or inpatient hospital admission. This was a primary intervention at the beginning of the study period in order to benefit from the maximum possible impact on the study indicator rate. It is believed that recuperative care will improve the member's health, reduce potential 90-day readmissions and support members with accessing community resources necessary to improve the health of the member. ATHRC provides the RCCO with a monthly report of those RCCO members who were enrolled in Respite Care during the prior month. This is a crucial first step for the RCCO to identify a homeless member given the constraints of the TREO SDAC data in not flagging homeless status. This discharge report contains data elements to assist with transition from respite care to the community: member name and ID, dates of admission to and discharge from respite care, reason for respite care enrollment, length of stay, attending provider, medical services received during stay, community social services received during stay, drug and alcohol counseling received, ED visits and hospital and discharge disposition. The data is aggregated monthly into a database and evaluated quarterly to allow for maximum impact on the study indicator rate at the time of the review. The PIP team meets quarterly to analyze the effects of the current established processes on the study indicator rate and make recommendations for changes where appropriate. This rapid cycle innovation may include RCCO 7 care coordination process changes, additional contracting with other collaborative partners, specifically behavioral health or substance abuse service providers at the respite care or hospital case manager point of member flow, or the provision of tools to the homeless member to assist with communication to aid care coordination. Even if the all-cause 90-day readmission rate is not impacted by this initial intervention, RCCO 7 intends to evaluate its impact on the overall health and well-being of the homeless member by analyzing the outcomes of those homeless members who had a 14 day respite care stay, compared to homeless members who did not. The data may also inform the effectiveness of a 14-day respite care stay versus a 30-day stay, for example, in which case RCCO 7 may want to adjust the contract with ATHRC.

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

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Barriers/Interventions Table:

Use the table below to list barriers, corresponding intervention descriptions, intervention type, target population, and implementation date. For each intervention, select if the intervention was (1) new, continued, or revised, and (2) member, provider, or system. Update the table as interventions are added, discontinued, or revised.

Date Implemented (MM/YY)	Select if Continued, New, or Revised	Select if Member, Provider, or System Intervention	Priority Ranking	Barrier	Intervention That Addresses the Barrier Listed in the Previous Column
01/14	Continued	System Intervention	100	A homeless member discharged from an inpatient hospital stay has nowhere to go off the street for continued recuperation	Contract with Ascending to Health Respite Care (ATHRC) to provide 14-day Respite Care stay to RCCO 7 homeless members discharged from an inpatient hospital admit
12/2015	New	System Intervention	100	Lack of attribution to a primary care manager disrupts the possibility of wrap around care for the homeless member	Identify a primary care manager for each member, and include other clinicians in the health team.
12/2015	New	System Intervention	100	Directing patient-centered care in accordance with the priorities of the homeless member	Member Health Assessment will be imperative to assessing the next step in the member's care continuum

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

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12/2015	New	System Intervention	125	Increase in number of members entering Ascending to Health Respite Care (ATHRC) with behavioral health needs	Ascending to Health Respite Care (ATHRC) working to integrate behavioral health into their model of care by collaborating with behavioral health providers in the community

Report the evaluation results for each intervention and describe the steps taken based on the evaluation results. Was each intervention successful? How were successful interventions continued or implemented on a larger scale? How were less-successful interventions revised or discontinued?

Evaluation results for each Intervention:

Three areas were evaluated to assess the impact of the initial intervention. First, analysis of the measurement period on the study indicator shows an increase of 10.7 percentage points in the 90-day readmission rate for this homeless population, whereas the 90-day readmission rate for the general population remains constant. Respite Care staff reports that patients are being discharged from inpatient hospital stays with elevated needs beyond what Respite Care can provide. Respite Care has been forced to return patients to the hospital for care, which may be impacting this rate. In addition, members are self-discharging prior to completion of the 14-day respite care stay. Many of these members disappear from the system but several self-readmit to respite care as their health deteriorates. The truncated respite care stay may be impacting the readmission rate and deserves closer analysis. Secondly, preliminary results indicate positive results towards more appropriate and timely navigation of health services post-discharge from respite care. This has been proven with a RCCO 7 member who was enrolled in the respite care program for the full 14 days. After respite care, Member A was discharged back to the status of homeless. Member A is a 27 year old male who presents with Crohn's Disease and severe chronic depression. Member A has had 187 specialist visits, 2 primary care visits, and 8 Emergency Department visits from January 2014 to present. Member A has had 7 inpatient hospital admits from December 2014 to July 2015 with each admit lasting from 2 days to almost 2 months. Member A was last seen in the Emergency Department on 09/21/2015 for displaced stoma. As a result of the coordination of care delivered by Ascending to Health Respite Care, Member A is currently off the street and living in a skilled nursing facility, where his care is actively managed. The

Appendix B: State of Colorado State Fiscal Year (SFY) 2015-16 PIP Summary Form: Medical Respite Care for Homeless RCOO Members Discharged from Hospital Inpatient Stay *for* Community Health Partnership—Region 7

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- Processes used to evaluate the effectiveness of the interventions and evaluation results.
- For remeasurement periods, how evaluation and analysis results guided continuation, revision, or discontinuation of interventions.

third area of positive improvement is the discharge report provided monthly by ATHRC. This report is invaluable in identifying homeless members discharged from a hospital inpatient admit to respite care where previously no identifier had existed. The RCCO begins the member's care coordination at the respite care discharge date, including notifying the PCMP of the member's health condition, or connecting the member with a PCMP or other provider for continuation of recuperation and care. All of this was considered when the PIP team met to evaluate failure modes and rank priorities for next step interventions.

Next steps for each intervention based on evaluation results:

The PIP team ranked the behavioral health needs of the homeless respite care members as the highest priority for next step intervention. More effectively managing pre-existing conditions was ranked second and interventions to address substance abuse was ranked third. Ascending to Health Respite Care staff consists of a full time Physician Assistant and a Registered Nurse, limiting Respite Care to cases within licensure and acuity. Respite Care staff are unable to treat the behavioral health and substance abuse needs of those members who do volunteer to enroll in the Respite Care program. Untangling the three highest priorities was challenging and so the PIP team has decided on a patient-centered, shared decision-making next step intervention. At the point of enrollment into respite care, RCCO 7 care coordinators will ask the member their health goals to assist in prioritizing next steps in case management. It may be that the member struggles with medication adherence for diabetes because of profound depression, in which case managing the depression will become the priority. The RCCO 7 care coordination team will identify a primary care manager for each member, and include other clinicians in the health team. This "Member Health Assessment" will be imperative to assessing the next step in the member's care continuum. The Member Health Assessment will be developed as a simple paper template that asks the member to rank on a scale of 1 – 3 their desired next step. Eventually, the paper template may be developed as a mobile device application and rolled out to other population cohorts.