Quality Improvement Plan
Name: Northeast Health Partners
RAE: 2
Date: September 30, 2022

1. Purpose/Mission Statement

Please describe your Organization's overall purpose/mission statement. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

Organizational Purpose

Northeast Health Partners, LLC (NHP) is the Regional Accountable Entity (RAE) for Region 2; an area comprised of 10 counties in the northeast section of Colorado. NHP's territory spans more than 20,000 square miles and includes more than 105,000 eligible members (as of the end of SFY21/22). The region was founded by four non-profit provider organizations serving the region: Sunrise Community Health, Salud Family Health Centers, North Range Behavioral Health, and Centennial Mental Health Center. NHP utilizes Beacon Health Options as an Administrative Services Organization (ASO). The organizational purpose for NHP has not changed across performance years and continues to be to serve Health First Colorado (Medicaid) members.

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

As with previous quality plans, this plan also serves as NHP's blueprint for the state fiscal year (SFY) 2022-2023 (i.e., July 1, 2022 – June 30, 2023). This plan includes goals and activities that will be prioritized for the fiscal year.

Overall Quality Health Strategy Mission and Vision

The mission of NHP's QI Department continues to be to ensure high value service delivery for Health First Colorado Medicaid members and health care providers. Additionally, the QI Department utilizes the principles of Lean, Six Sigma, and Total Quality Management (TQM) to eliminate waste and fragmentation between service providers and improve processes across the broader system.

The FY20-21[1] quality plan noted the *Science of Improvement and Deming's Theory of Profound Knowledge*[2] as a key component to the quality strategy. This also has not changed between fiscal years. As noted previously, the four basic tenets of Deming's theory are:

1. To make an "improvement," it's critical to understand the system as a whole and the various components within the system. Understanding the integration of services and the linkages between components in a broader system helps identify gaps in service operations and areas for processes.

[1] Northeast Health Partners. *Quality Improvement Plan.* Submitted to HCPF on October 28, 2020.
[2] Langley, G.J. et al. (1996). The Improvement Guide: A practical approach to enhancing organizational performance. San Francisco: Jossey Bass.

2. Variation within a system is natural, and data is necessary to understand the reason for the variation. Because we operate in a human-driven industry (as opposed to machine-oriented manufacturing), a process is expected to have variation between independent organizations and personnel. These variations help to identifying areas where processes can be improved.

3. The "science of improvement" applies a scientific method to improvement by making predictions about implemented changes. Improving processes follows the scientific method of testing the impact of interventions, and an effective intervention is developed through systematic data collection and analysis.

4. Understanding that people are parts of system improvement and understanding human behavior is important for successful improvement efforts. While tied to process variations, quality improvement initiatives must be applied with a human-centric lens with the understanding that outside influences (such as COVID-19) can impact quality and the efficacy of quality improvement initiatives.

NHP's approach to these tenets exists within the Total Quality Management (TQM) framework; a model focused on meeting the needs of those it serves while engaging the entire organization and its stakeholders to embrace quality improvement. The tenets of a TQM system are outlined below to include a focus on the customer (in this case NHP's Medicaid members and clinical partners), integrating smaller systems into a larger strategic direction, engaging staff and people across the region, standardizing processes, strategic thinking, emphasizing continual improvement, fact-based decision-making, and effective communication.[3]

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

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

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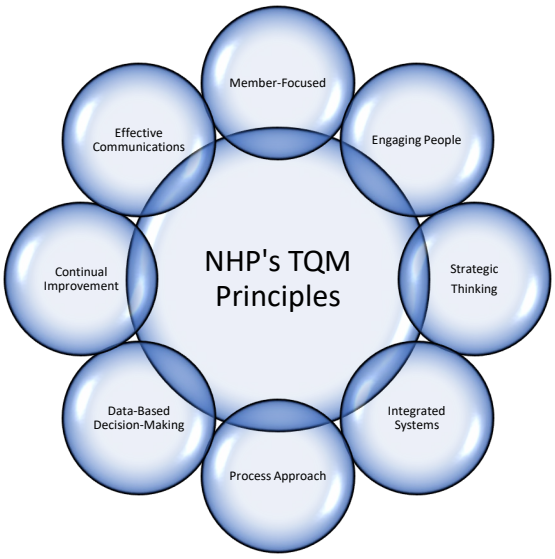

Figure 1. Total Quality Management Framework

NHP also adopted the Define, Measure, Analyze, Improve, and Control (DMAIC) method of process and performance improvement. This method is data-driven, and focuses on identifying root causes for targeted intervention development. This cycle begins with defining the problem, and then collects data on variables associated with the problem. The analysis phase yields insights into root causes or performance gaps, and the improvement phase is the implementation of the corrective intervention. The process ends in a reassessment of the impact to determine whether the intervention is kept or revised. The process repeats itself for continual improvement.

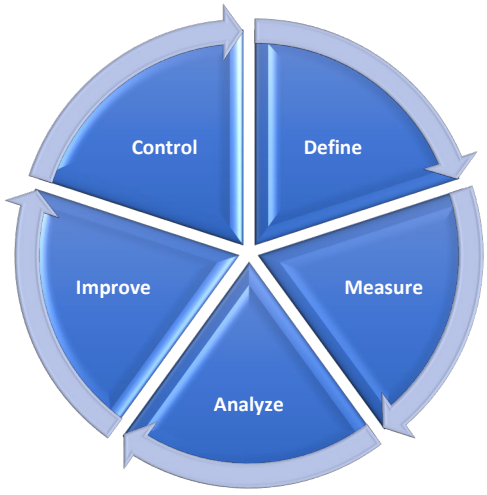

Figure 2. DMAIC Process

This methodology approach can be applied across disease states, programs and departments, and mirrors other improvement methodologies including PDSA (Plan, Do, Study, Act), A3, and the medical

model where interventions are data-driven, assessed for efficacy, and either maintained or retooled depending on the impact assessment. This approach is universally applied across NHP's programs including Quality, Condition Management, Public/Population Health, and Complex Care Management in places requiring performance improvement.

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2. Yearly Objectives/Top Priorities

Please describe your quality objectives and top priorities for this fiscal year. Note: Only update this when applicable, when there are no updates, just copy and paste from a previous submission.

The QI Program at NHP established key initiatives for SFY22/23 through an evaluation of its accomplishments to-date, and the identified gaps and barriers observed during the last fiscal year. Initiatives for SFY22/23 are noted at a high level below in Table 1.

Table 1. Key Initiatives for SFY22/23

Project	Goal / Activity
411 Audit	• Continue to maintain our inter-rater reliability with HSAG over-reads. • Engage in the 411 QUIP with providers who did not meet established standards.
All performance measures	• Improve KPI performance to meet pre-COVID levels. • Expand single-source reporting and visualizations on KPIs, BHIP, Performance Pool performance to include clinic-level analysis. • Maintain regional access to performance reports and action items across KPIs. • Continue partnering with individual clinics/sites to establish targeted performance improvement activities for lagging performance indicators. • Maintain strong performance in Risk-Adjusted Per Member Per Month (PMPM) measure.
Behavioral Health Incentives Program Measures (BHIP)	• Continue performing at or above the regional target for both Depression screening (Gate) and Follow-up for Positive Depression Screening measures. • Achieve regional goals for the BH Screen/Assessment for children entering Foster Care. • Expand previously established performance improvement initiatives at the clinic-level for lagging BHIP performance.
Performance Pool (PP)	• Maintain performance in Extended Care Coordination, acknowledging the change in populations being served through ECC. • Maintain strong performance in Department of Corrections (DOC) BH Engagement Measure. • Maintain strong performance in Medication Adherence Measures. • Establish clinic-level performance improvement initiatives for lagging performance.

Performance Improvement	• Expand the number of independent performance improvement projects to meet:
	  ○ 2 out of 5 KPI metrics
	  ○ 3 out of 5 BHIP measures
	  ○ 3 out of 7 Performance Pool Measures
	• Improve Prenatal Engagement rates to meet Tier 1 levels
	• Improve Dental Engagement to meet Tier 1 levels

PIP (Performance Improvement Project)	• Finalize the Module 4 documents for the SFY21/22 PIP • Establish partnerships with practices for the SFY22/23 PIP

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Project	Goal / Activity
ED Visits	• Expand the ED Dashboard Report to include information on Admission/Discharge/Transfer (ADT) files to better understand the growing trend in ED utilization that began in February of 2021. • Partner with hospitals to assess hospital-level perspectives • Implement focus groups to understand member-level perspectives on ED use.
Practice Transformation Program (PT)	• Expand on Practice Transformation work from SFY21/22 • Implement the Behavioral Health Practice Transformation program • Track milestones for Prescriber Tool implementation
Hospital Transformation Program (HTP)	• Establish data collection feeds for all hospitals to utilize in alignment with the HTP goals. • Incorporate HTP data to Health Cloud or other Health Information Exchange system to begin closed-loop communications to the regional hospitals.
Prescriber Tool	• Help position practices for success at implementing the Prescriber Tool through a milestone program including workflow changes, trainings, and developing tracking tools.

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3. Program Leadership

Please list the individuals who are in your quality program. Please include their contact information.
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Kari Snelson, LCSW, CHC Executive Director Chief Compliance Officer Northeast Health Partners, LLC Phone: [redacted] Email: [redacted]	Brian Robertson, PhD, MPH, CSSBB, CMQ/OE Chief Operating Officer Director, Quality Improvement Northeast Health Partners, LLC Phone: [redacted] Email: [redacted]
Mark Wallace, MD, MPH Chief Clinical Officer Northeast Health Partners, LLC Phone: [redacted] Email: [redacted]	TBD Manager, Quality Improvement Northeast Health Partners, LLC Phone: TBD Email: TBD
Wayne Watkins Director, Health Information Technology & Data Northeast Health Partners, LLC Phone: [redacted] Email: [redacted]	John Mahalik, PhD, MPA Director, Quality Management Beacon Health Options Phone: [redacted] Email: [redacted]
Jeremy White Quality Manager Beacon Health Options Phone: [redacted] Email: [redacted]	Michael Clark Director, Data Analytics and Reporting Beacon Health Options Phone: [redacted] Email: [redacted]
	Robert McAlonan Senior Director, Provider Quality Beacon Health Options Phone: [redacted] Email: [redacted]

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4. SWOT Analysis & Action Plan

Please provide a SWOT (Strengths, weakness, opportunities and threats) for any program/project that the Department has specified needed more information. If you have not been asked by the Department to provide more information, please leave this page blank.

Note: The Department has not requested this.

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Please fill out the following template for all projects that are associated with the programs listed in the gray boxes.

Goal	Fiscal Year (22/23) New & Ongoing Objectives	Targeted Due Date	Update
Performance Improvement Projects			
Maintain the Increased rates of Depression Screen and Follow-ups at Sunrise Community Health	a) Finish data analysis and performance visualizations b) Ensure statistically significant improvement for both screening and follow-up rates c) Disseminate findings and lessons learned	June 30, 2023	NHP tracked performance on both screening and follow-ups, and meets with clinical practices on a monthly basis. We will finalize charting with a 90-day claims runout, assess for significance, and engage Sunrise for any additional PI activities. Lessons learned information (Module 4) will also be completed and disseminated.
See Demonstrated Improvement on Scores Related to the Chart Audits for the 411 Quality Improvement Project (QuIP)	Meet all project requirements associated with the 411 Quality Improvement Project (QuIP).	June 30, 2023	NHP strives for excellence in the annual Claims and Encounter Validation Audit. As with past 411 audits, NHP performed very well across the three service categories. NHP saw high levels of accuracy in Psychotherapy, Residential, and Inpatient audit sections. NHP will tailors training specific to the areas of improvement found in the audit. Even though NHP saw high agreements of the aggregate scores, NHP will focus on specific providers where the scores were determined to fall below the threshold of 90%. NHP engaged these providers by offering training and asking for corrective action plans where warranted. Further, NHP, in conjunction with North Range Behavioral Health, will engage in a QUIP focusing on improving scores in the psychotherapy services category for the place of service encounter category in FY23.

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Collection and Submission of Performance Measurement Data			
Achieve Performance Targets for Prenatal Engagement and Well Visit KPIs	a) Achieve Tier 1 levels for Prenatal Engagement b) Achieve Targets for Well Visits	June 30, 2023	NHP was performing at a Tier 2 level for the Prenatal Engagement KPI before the goal shift at the beginning of the SFY22 performance year. Since then, NHP has been hovering on the edge of the Tier 1 goal; missing the measure in Quarter 2. Performance Improvement activities are underway to explore prenatal engagement codes to better understand gaps in performance. The Well Visit KPI measure changed in SFY22 to become a composite measure of two different levels (age 3-21 years and either 0-15 months or 15-30 month visits). Data was not readily accessible in the DAP on the measures until the end of March, and are only updated on a quarterly basis; limiting insight on regional performance. PI activities were established with our largest clinic to explore well visit action lists from the DAP, identifying over 125 members who had completed well visits in the medical record, but were still on the action list. Data exploration is still underway.

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Utilize Performance Improvement Methodologies to Meet at Least One New KPI Goal	a) Continue assessing performance at site/clinic levels b) Initiate targeted PI activities with sites/clinics as necessary	June 30, 2023	NHP began a process to develop specific, clinic level performance improvement projects via the Performance Measures Action Plan (PMAP) plan and utilizing the Define, Measure, Analyze, Improve, and Control (DMAIC) process found in the Lean Six Sigma discipline. Utilizing a review of clinic level performance data, NHP will continue to partner with and offer support to clinics in conducting individual performance improvement projects across the network. Regional performance was monitored, and KPI performance fell across all measures at the end of Quarter 1. PI activities were initiated with the largest clinics to explore prenatal engagement and well visits, and DAP performance data and action item lists were distributed directly to sites (as opposed to sites extracting information from the DAP). NHP also began engaging with smaller clinics for better regional impacts.
Exceed Performance Thresholds for 7-Day Follow-Up after Inpatient Mental Health Discharge	a) Identify and understand performance trends and improvement opportunities b) Map discharge processes with hospitals	June 30, 2023	NHP began a process mapping exercise with North Range to look at discharge notifications and the integration of North Colorado Health Alliance (NCHA), a local care coordination entity, into that process to better reach members and improve performance on the BHIP measure. NHP plans to engage with hospitals and expand this exercise to standardize discharge communications between the hospital and the mental health clinic.

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Continue to Exceed Performance Thresholds for Depression Screening Follow-Up	a) Identify and understand performance trends and improvement opportunities b) Initiate targeted PI activities with sites/clinics if necessary	June 30, 2023	NHP has been exceeding the depression screening target since November of 2020, and successfully met the gate measure for the first time in SFY21. To help support performance improvement efforts on this goal, NHP began tracking gate measure performance in SFY22. NHP will continue to monitor performance for screenings and follow-ups, and will implement targeted PI projects with clinics as needed.
Continue exceeding Performance Thresholds for Extended Care Coordination	a) Identify and understand performance trends and improvement opportunities b) Establish mitigation strategies as needed	June 30, 2023	Extended Care Coordination has exceeded the performance threshold since November of 2019, and opted to work with the State to re-scope the complex member definition for SFY21/22. New definitions, baselines and targets, in addition to the 90-day care plan language, have impacted performance compared to previous years. Baseline data and performance could not be accurately assessed until April of 2022 due to the 90-day care plan language in the specification document, and PI activities were not directly conducted in SFY21/22 due to limited history on performance or variables impacting performance. NHP looks to continue its history of strong ECC performance and will engage in targeted PI activities as necessary throughout SFY22/23.

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Continue exceeding Performance Thresholds for BH Engagement Following DOC Discharge	a) Identify performance trends and improvement opportunities b) Establish mitigation strategies as needed	June 30, 2023	BH Engagement after DOC release again met the goal for SFY21/22. NHP hopes to continue this trend and will engage in targeted PI activities as necessary. NHP established a pool of funds to support organizations who help DOC members (halfway houses, work trainings, etc.) to help members better return to and assimilate in the community.
Continue Clinic-Level Performance Monitoring and Performance Improvement Projects	a) Maintain the DAP project across the region to provide DAP performance and action item lists direct to clinics b) Create targeted PI activities in partnership with clinics	June 30, 2023	NHP's QI Director and IT Director with support from the Beacon QM team established a pilot program in early SFY21/22 for RAE 2 providers to have DAP charts and action item lists sent directly to them through secured e-mail. The pilot was started with 3 clinics, and was subsequently expanded to 28 clinical groups that manage over 95% of NHPs attributed members. NHP plans to utilize the DAP chart communications to create clinic-level Performance Improvement projects.

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Member Experience of Care			
Utilize CAHPS and ECHO surveys to Assess and Improve Member Satisfaction	a) Meet or exceed satisfaction results from SFY21/22 on common measures. b) Present survey results to quality committees for additional input and for performance improvement activities.	June 30, 2023	CAHPS survey results were received and presented at the QI/Pop Health Meeting, Regional PIAC, and Quality Management Meeting. NHP shared the results with surveyed sites for targeted interventions. NHP will take the results of the CAHPS data received in FY23 and impalement targeted interventions where low satisfaction scores are reported. ECHO surveys were not conducted in SFY21/22, but may be incorporated in SFY22/23. NHP will present results regionally, and will look to work with clinical sites to improve performance as necessary.
Continue Grievances and Appeals Processes and Oversight	a) Continue reporting on grievances and appeals trends to quality and clinical leadership (at least quarterly). b) Continue to utilize the Member Engagement Advisory Committee to ensure additional level of member experience is incorporated into quality activities.	June 30, 2023	The member services team trends all grievances and appeals on a quarterly basis and presents findings to the quality improvement committee. NHP will continue to report grievance and appeals trends and engage shareholders on how to target any identified trends. The member services team meets with the Member Services Subcommittee on a quarterly basis to provide oversight on the complaints received by the shareholder advocates. The member services team will continue to host quarterly Member Experience Advisory Council meetings to obtain member input on their experience in health care.

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Under and Over Utilization of Services			
Continue Monitoring the BH Penetration Rate	a) Improve BH penetration rates. b) Continue reporting on special populations for penetration rates, including foster care, rate groups and age groups.	June 30, 2023	Rolling penetration rates for SFY21/22 were 16.6%, which is lower than the previous year. This decreased rate may be due to the continued increase in membership and a decrease in average DCG scores across the year.
Improve and Monitor Hospital Readmissions Performance	a) Continue reporting on 30-day hospital readmissions. b) Establish a performance improvement opportunity on suboptimal performance.	June 30, 2023	Current reports exist for 30-day readmissions and are reported quarterly. SFY22 reported a 9.08% readmission rate, which is lower than the 9.4% rate in SFY21.
Improve and monitor Average Length of Stay (ALOS) performance	a) Continue reporting on ALOS. b) Establish a performance improvement opportunity on suboptimal performance.	June 30, 2023	Current performance is reported monthly in the UM Committee. ALOS has generally had a downward trend and SFY22 noted an average LOS of 6.1 days.
Improve and monitor Inpatient Utilization	a) Continue reporting on inpatient utilization. b) Establish a performance improvement opportunity on suboptimal performance.	Quarterly	Current performance is reported monthly in the UM Committee. SFY22 saw 837 inpatient admissions for 5,106 inpatient days.
Quality and Appropriateness of Care Furnished to Members			
Continue Care Coordination Audits	a) Align audited standards to definitions and requirements.	June 30, 2023	A new audit template was developed for SFY21/22 audits which were performed in the summer of 2022. The tool aligns all items with NHP Care Coordination Policy and/or HCPF priority areas and will be implemented during the transition to a new definition of Complex members across care coordination entities. Audit results will be reviewed by NHP care coordination and quality leadership to tailor training offerings during this transition and follow-up audits may be performed as appropriate.

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Quality of Care Concerns			
Continue Quality of Care Processes and Oversight	a) Send quarterly reports HCPF.	Quarterly	Quality of Care Committee Meetings continue their monthly cadence or are scheduled as needed. The state reporting document to use for reporting issues was finalized by the state in Q2 of SFY21/22, and the first quarterly reports were submitted in Q2 of SFY21/22. NHP looks to continue this reporting cadence with the state.

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External Quality Review			
Meet all Requirements Associated with the EQRO Audits	Comply with all site review activities for SFY22/23.	June 30, 2023	Stemming from the SFY21/22 EQRO audit, two standards were issued a corrective action. These standards were Member Information Requirements and Early Periodic Screening and Diagnosis and Treatment (EPSDT) For the Member Information Requirements standard, HSAG issued two corrective actions. The first corrective action surrounds the need for NHP to revise critical member materials to include all required components of a tagline. The second corrective action related to the Member Information Requirements standard concerns. NHP needing to develop and implement a mechanism to monitor that, upon request, members are provided with printed materials within five business days and at no cost. NHP's general member webpage and provider directory webpage included a statement that materials can be printed but did not include "within five business days." HSAG recommends that, as best practice, the full statement be placed in prominent locations on the website, particularly where critical documents are linked and/or downloadable (i.e., the *New Member Welcome Packet* page). NHP will continue to work with HSAG in order to close out the corrective action related to the FY21/22 review. Furthermore, NHP will work in conjunction with HSAG to complete the FY 22/23 review.

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Advisory Committees and Learning Collaboratives			
Maintain the Quality Management Committee Activities	Maintain bi-monthly Quality Management (QM) and QI/Pop Health Committees to monitor QI Program initiatives throughout the region.	Bimonthly	NHP's QM committee and Population Health has been meeting bi-monthly since September of 2020, and will continue to meet on this schedule for SFY22/23. Commonly discussed topics will continue to include regional and state updates, KPI, BHIP, and Performance Pool metric performance, and performance improvement activities in addition to other pressing regional quality initiatives.
Maintain Regional Program Improvement Advisory Committee (PIAC)	a) Continue aligning activities and content to the State PIAC.	Quarterly	The NHP Regional PIAC meets quarterly. Topics routinely include State PIAC discussion topics such as Public Health Emergency (PHE) ending, performance measure changes, population health initiatives, and subcommittee updates.
Maintain Monthly First Fridays Quality Forum Meetings	Maintain a monthly-scheduled regional meeting to cover quality-related topics with stakeholders.	Monthly	NHP established a monthly communication and training venue at the end of SFY21/22 called the "First Fridays Quality Forum." This meeting occurs on the first Friday of every month, and NHP looks to maintain this venue and to discuss relevant regional topics for SFY22/23.
Quality and Compliance Monitoring Activities			
Meet all Encounter Data Validation Audit Requirements	Improve over-read scores with HSAG.	Spring 2023	Internally-calculated inter-rater reliability (IRR) was 82.2% This was a drop from an IRR rate of 86.8% in SFY21/22 likely due to new auditors, and NHP will look to meet or exceed these scores for SFY22/23.

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Continue Behavioral Health Compliance Auditing	a) Establish data collection methods to track results on audited standards. b) Trend performance to proactively identify opportunities and training needs.	Monthly	NHP audited 164 charts across 32 unique audits covering Detox, SUD, IOP, CMHCs, Residential Treatment Centers, MAT Clinics, Inpatient Facilities, and the Independent Provider Network with total aggregate scores of 87.45%.
Alternative Payment Model			
Hospital Transformation Program	a) Implement Phase II of the HTP data collection Plan b) Troubleshoot technology issues	June 30, 2023	NHP established a multi-phased approach to include a manual communication pathway for hospitals in Region 2 that did not have an existing communication pathway to the RAE (Phase I), a communication pathway that includes incorporating data into NHP's Health Information Exchange (Phase II), and closed-loop communication to hospitals with automation (Phase III).

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Practice Transformation (PT)	a) Practices achieve 90% of milestones. b) Establish a Behavioral Health Practice Transformation Program c) Align PT milestones to KPIs and BHIP measures. d) Integrate Prescriber Tool implementation into Practice Transformation	June 30, 2023	The Practice Transformation program was implemented in SFY20/21 to establish a "culture of quality" within clinics. The program evolved in SFY21/22 to help build on previous efforts to maintain the results of the previous year. NHP continues to engage practices and looks to improve on the previous fiscal year's scores in SFY22/23. Further, NHP evolved the PT program to help practices improve performance on KPIs and BHIP measures. NHP launched the Behavioral Health Practice Transformation pilot program on July 1, 2022 and will monitor progress on milestones and the programmatic impact on BHIP Measures. NHP will align Practice Transformation milestones to impact KPIs and BHIP Measures. Lastly, NHP utilized the Practice Transformation Coaches to discuss and support Prescriber Tool implementation. PT Coaches helped NHP achieve a 100% response rate for submitting the Prescriber Tool Attestation by the June 30 deadline, and designed a milestone program for SFY23 to help practices implement and use the tool.