Community Integration Services: Rapid Cycle Assessment 2022-Q2

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Department of Human Services
Med-QUEST Division

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Overview

The evaluation team examined Health Plan (HP) reports for the reporting period—2022 Quarter 2—April 1, 2022, through June 30, 2022. These reports included both quantitative and qualitative data. Quantitative data consisted of member-level data and aggregate-level data. Qualitative data included feedback from HPs on program implementation, success, and challenges.

Based on this data, the evaluation team examined progress toward Key Performance Indicators (KPI). Individually, HPs met between 5 and 8 KPIs. At an aggregate level, CIS met 5/14 KPIs. **However, data quality continues to be an issue, and these results should be interpreted cautiously.**

Health Plan	KPIs Met
AlohaCare	8/14
HMSA	6/14
Kaiser	5/13*
Ohana	8/13*
United	7/13*

*Unable to evaluate at least one KPI based on data submitted.

Because of the data quality issues and the fact that many HPs continued to express many challenges with implementation, particularly outreaching hard-to-reach members, the evaluation team used the Rapid Cycle Assessment meeting with Health Plans to discuss and troubleshoot these issues. Additionally, we revisited the logic model to see if any processes had changed (or needed to change) in order to ensure successful implementation.

Unfortunately, Health Plans were hesitant to contribute to discussion or to the online forum for sharing tips and questions [https://padlet.com/hannahip1/u93gse5bie6fmrvl].

The remainder of this report presents tentative enrollment numbers, progress towards KPIs and other performance indicators, data issues, and conclusions/recommendations for Med-QUEST and the evaluation team moving forward.

CIS Numbers

Based on the member-level data files (MLDFs) submitted by all 5 Health Plans:

- 897 members were enrolled in CIS at any point during the quarter.
- 94 were newly enrolled during the quarter
- 137 disenrolled during the quarter
  - 3% (n=4) lost eligibility
  - <1% (n=1) lost to follow-up
  - 90% (n=123) “other” reason
  - 7% (n=9) missing

However, the number of all enrolled CIS members is inconsistent with data from homeless service providers suggests approximately 80-120 people had received any CIS services as of June 30, 2022.

Additionally, data issues suggest that this number is an overestimate. For example, some Health Plans included members who were referred and consented in previous quarters as “newly enrolled” this quarter. At least two Health Plans had multiple duplicate members included in their MLDFs.

Progress toward KPIs

Metric	Description	Values	KPI Progress Bar*	KPI Target
Aggregage Metric 1	Percent of members assessed for CIS eligibility	0.2%		
Aggregage Metric 2	Percent of potentially eligible members who were identified through Health Plan analytics and internal referrals	61.8%		>70%
Aggregage Metric 3	Percent of potentially eligible members confirmed (in)eligible within the allowed window (15 days for external referrals; 30 days for internal referrals)	26.0%		>90%
Aggregage Metric 4	Percent of members identified as potentially eligible for CIS in a prior reporting period whose eligibility was confirmed (backlog)	9.8%		
Aggregage Metric 5	Percent of consented/enrolled members who were already receiving homeless services at CIS enrollment	141.8%		
Aggregage Metric 6	Percent of eligible members who consented to participate in CIS within 10 days of eligibility confirmation	44.7%		>90%
Aggregage Metric 7	Percent of eligible members who declined participation in CIS	0.0%		<20%
Aggregage Metric 8	Percent of new CIS members who completed their initial assesment within 15 days of consent	18.2%		>90%
Aggregage Metrics 9	Percent of new CIS members who completed their initial CIS Health Action Plan Addendum within 30 days of the initial assessment	32.7%		
Aggregage Metrics 10	Percent of existing CIS members who received a CIS Re-Assessment/Plan Review and Update within 90 days	2.4%		>85%
Aggregage Metrics 11	Percent of existing CIS members who are overdue for a CIS Re-Assessment/Plan Review and Update	0.0%		
Aggregage Metrics 12	Attrition from CIS over the reporting period	0.0%		
Aggregage Metrics 13	Percent of CIS members who were due for Medicaid eligibility re-determination who remained in Medicaid on the last day of the reporting	94.0%		>80%
Aggregage Metrics 14	Percent of CIS members who transitioned from pre-tenancy to tenancy	1.5%		>10%
Aggregage Metrics 15	Percent of CIS members are in tenancy	39.1%		
Aggregage Metrics 16	Percent of CIS members who were lost to follow up	0.8%		<10%
Aggregage Metrics 17	Percent of existing and new CIS members who have completed a HAP and receiving at least two CIS services per month	14.2%		
Aggregage Metrics 18	Percent of existing and new CIS members who have completed a HAP whose Assessments/Health Action Plans (CIS Addendum) were shared with their PCP	36.0%		>90%
Aggregage Metrics 19	Percent of CIS members who have not had a routine check-up within the past year	94.3%		<25%
Aggregage Metrics 20	Percent of CIS members with two or more unplanned hospitalizations	0.8%		<15%
Aggregage Metrics 21	Percent of CIS members with two or more ER Visits	0.4%		<15%

Aggregating data from the member-level data files across all Health Plans, evaluators examined progress toward KPIs. Notably, these numbers are based on recalculations by the evaluation team after cleaning MLDFs (removing duplicates, correcting formulas, etc.). Total KPIs met across all programs= 5/14

Additional metrics to note:

- Average time from identification of potentially eligible members and confirmation of eligibility = 26.76 days (15.81 days for external referrals; 33.87 for internal referrals)
- Average time from confirmation of eligibility to consent = 125 days
- Average time from consent to assessment = 49.78 days
- 25 assessments were completed this quarter, with varying levels of completeness.

Data Quality Issues

Findings presented in this report should be interpreted cautiously due to pervasive data quality issues. Evaluators touched on these issues in this quarter's Rapid Cycle Assessment meeting with Health Plans and will meet with each Health Plan individually in the coming month.

Some of the most common issues include:

- Health Plan's MLDFs often confused coding for missing data with "N/A" data fields and data which is "0". For example, some HPs entered "0" for missing data.
- Some HPs included members from previous quarters in this quarter's data. For example, some members were marked as "newly enrolled", but their referral, consent, and assessment dates were from previous quarters.
- Duplicate members were entered in the MLDFs.
- Some Health Plans confirmed eligibility before referral. Similarly, some HPs consented members (sometimes up to a year or more) before confirming eligibility. It is unclear if this inconsistency is a mistake in data entry or if it is a change to program process/implementation.

Additional Data Issues

Additional data issues include data collection format and finding the best source for outcomes.

Some of the formulas in the aggregate-level data file (ALDF) are incorrect (or are only correct under certain circumstances). The evaluation team added these formulas at the request of Health Plans to help populate numbers from the member-level data file. HPs have the option to enter their own numbers or use these calculations Unfortunately, some of the necessary calculations are difficult to do with excel formulas and do not hold under all circumstances.

Additionally, several HPs indicated that correct formulas were incorrect and entered their own numbers entered manually in the ALDF. These numbers do not match the MLDF data. Overall, there continues to be a mis-match between numbers reported in the aggregate-level data file and the MLDF. The evaluation team and Med-QUEST are working with a consulting company to develop a better submission process that does not require excel sheets and formulas (e.g., a flat file format that can then be analyzed by evaluators).

The evaluation team and MQD need to work with Health Plans to find a way to accurately track housing outcomes. Claims data will not have this information, which is the current data source listed for these fields in the member-level data file.

Conclusions and Recommendations

Based on submitted data, the evaluation team makes the following recommendations for itself and MQD moving forward:

[KPI 4] Extend time window between eligibility confirmation and consent to 30 days. Currently the KPI requires more than 90% of members be consented within 10 days. The average time between confirmation and consent is 125 days. This length of time is likely reflective of HPs' difficulty with outreaching hard-to-reach members and will hopefully decrease as HPs become more adept at outreach. However, we recommend extending this time window to at least 30 days. The Oahu Continuum of Care's Coordinated Entry System's standard from referral to intake is 15 days, with programs taking anywhere from 6 to 30 days. And these programs are experts in outreaching people experiencing homelessness and housing instability.

[KPI 6] Extend time window between consent and assessment to 30 days. Similarly, only 18% of members completed their assessments within 15 days of consent. Given the length of the assessment(s), we suggest extending the time window to 30 days.

Include additional codes for disenrollment reasons. Given that 90% of dis-enrollments were for "other" reasons, it may be helpful to talk to HPs about what are some of the most common reasons and include codes for those reasons in the MLDF.

Conclusions and Recommendations

Clarification on when to consider a member "enrolled" in CIS. There seems to be different understandings across HPs on when to consider a member enrolled in CIS. Additionally, reported numbers of enrollment do not match data reported from homeless service providers. We recommend clarifying enrollment status with HPs and working with them to determine how many people are *actually receiving* CIS services.

Find a way to accurately track housing outcomes. Claims data will not have this information, which is the current data source listed for these fields in the member-level data file. Evaluators and MQD should work with HPs to find the best data source for this information and/or work with HPs to develop a system to track this information internally.

Continue to work to improve the data submission process. Many of the data issues could be resolved with a better data submission process (e.g., use of flat file format). We suggest evaluators and MQD continue working towards a process in which HPs can easily pull and submit a member-level data file that evaluators can then analyze. Having HPs both collect and calculate their data seems to add extra opportunity for error.