Community Integration Services: Rapid Cycle Assessment 2023-Q3

DECEMBER 1, 2023

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Prepared for: Med-QUEST Division

UNIVERSITY of HAWAIʻI® MĀNOA

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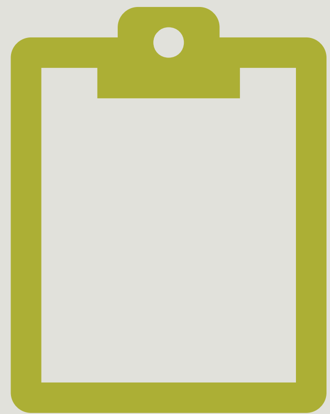

Overview

This report presents updates from the 2023 Quarter 3 (Q3) Rapid Cycle Assessment (RCA) for Community Integration Services (CIS), covering the reporting period July 1, 2023, through September 30, 2023. The RCA primarily focuses on progress toward Key Performance Indicators (KPIs) in 2023 Q3 and Q3 CIS member characteristics from Q3 assessments. Data includes qualitative responses to questionnaires and quantitative data submitted for the quarter by the Health Plans (HPs). The quarterly data reports include HP administrative data and member self-reported assessment data.

KPIs measured in this report are the original KPIs developed in 2021. Notably, MQD revised KPIs in the Health Plan Manual released on October 1, 2023 (see Appendix C for both original and updated KPIs). Targets or "benchmarks" for KPIs are established in the CIS Review Tool version two.

Preliminary results were shared with the HPs, Med-QUEST(MQD), and participating homeless service providers at the Rapid Cycle Assessment meeting, held over Zoom on December 1, 2023.

The remaining sections of this report provide overall numbers for the quarter, progress towards KPIs, and assessment data findings. It concludes with a summary of findings and recommendations for MQD.

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CIS Numbers for 2023-Q3

Quantitative data reported by HPs showed 2,028 unique members had been assigned any CIS H code during the quarter (Table 1). Of this number, 342 members had consented to participate in CIS, 58 of which were newly consented during the quarter (new members); the remaining 284 consented in a previous quarter (existing members). HPs reported that 832 members received pre-tenancy or tenancy services during the quarter, most of whom were reported to be receiving pre-tenancy (*n* = 503). HPs reported that 257 members were referred during the quarter and that 176 were confirmed eligible.

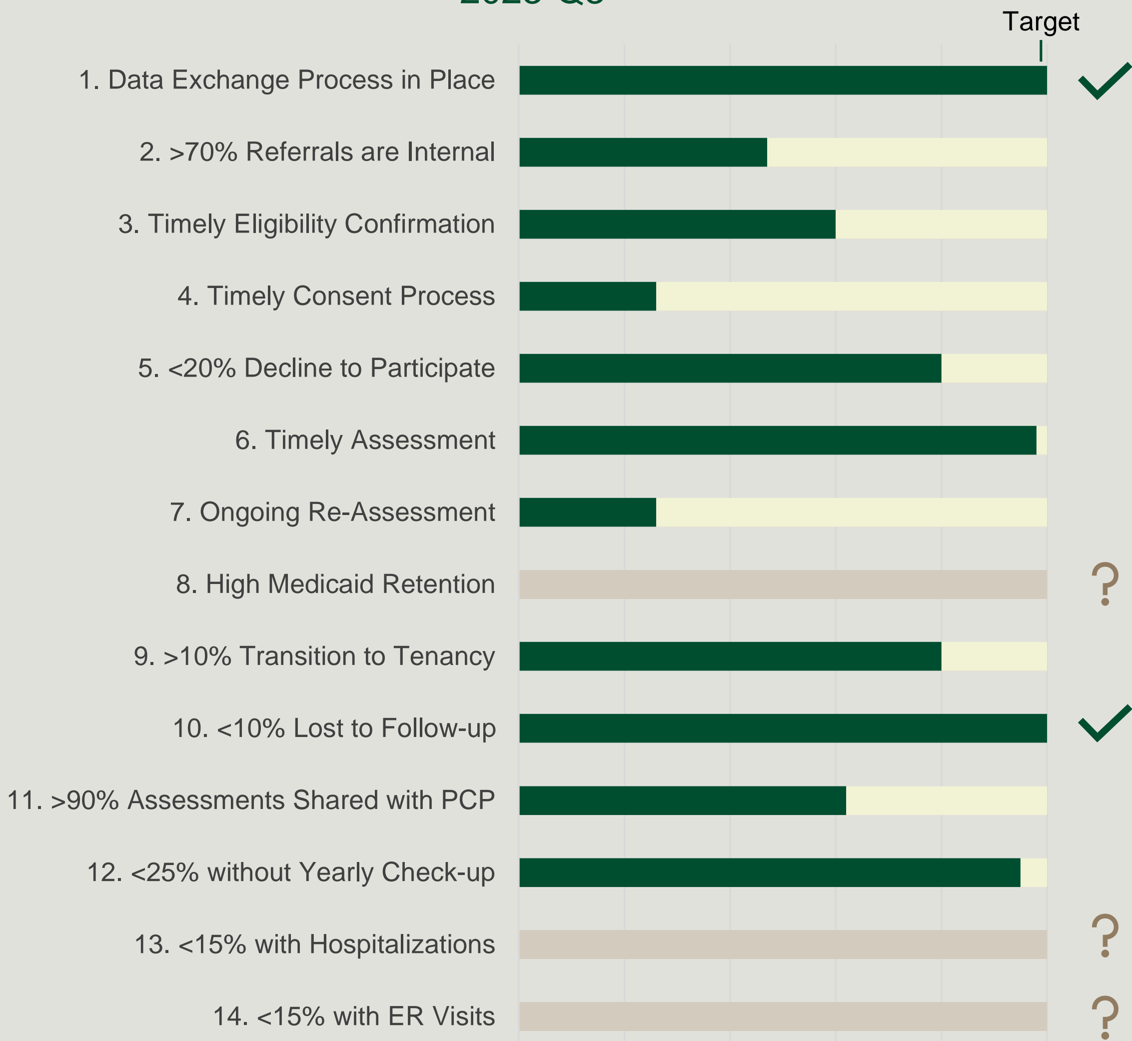
Table 1. Number of Members in 2023-Q3 Who Were:

Assigned Any H Code	2,028	
Newly Referred	257	
Newly Confirmed Eligible	176	
Consented at Any Point (New & Existing)	342	Enrolled
Newly Consented (New)	*58*	Enrolled
Consented Previously (Existing)	*284*	Enrolled
Receiving Pre-Tenancy or Tenancy	832	Enrolled & Receiving Services
Receiving Pre-tenancy	*503*	Enrolled & Receiving Services
Receiving Tenancy	*329*	Enrolled & Receiving Services
Transitioned from Pre-Tenancy to Tenancy	*57*	Enrolled & Receiving Services

We would expect the number of new and existing members who had consented to CIS at any point to be equal to or higher than the number of members receiving tenancy or pre-tenancy services. However, the number of members HPs reported had received services was almost three times more than the number of members reported to have consented to CIS. Additionally, encounters data showed that only 46 members had encounters during the quarter. Thus, it is not possible to determine how many members received CIS during quarter three of 2023. This data quality issue also complicates determining progress toward KPIs, discussed in the next section. When assessing KPIs that pertain to enrolled members, the evaluation team only considered members who had provided consent to services, in part, because these members were the members with more complete data.

KPI Progress for 2023-Q3

The evaluation team combined data across Health Plans to examine progress towards KPIs in Q3. These KPIS are assessed in quarterly reviews for individual HPs. Taken together, CIS met two of the 14 KPIs and came close to meeting two additional KPIs. The team was unable to evaluate three KPIs due to incomplete data. The rest of this section focuses on progress toward each individual KPI, providing detailed data on each metric.



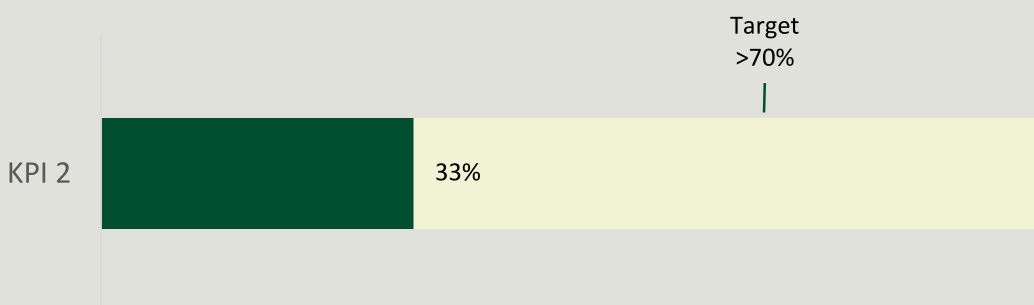
KPI 1. Data Exchange Process in Place

All Health Plans have an active and ongoing data exchange process and/or data sharing agreement with HMIS and CES to identify members who are potentially eligible for CIS and/or track CIS members' prioritization for housing supports.

Based on Health Plans' qualitative responses on quarterly reports, all HPs have some form of data sharing agreement with the Homelessness Management Information System (HMIS) and a relationship with the Coordinated Entry System (CES). However, each HP's access to HMIS is primarily read-only and limited to members who have been identified by homeless service providers to be associated with the HP. Additionally, HPs reported that they do not have access to the neighboring islands' HMIS, managed by Bridging the Gap. HPs have consistently noted that lack of access to the neighboring islands' HMIS is a substantial barrier to service provision and care coordination for members who do not live on Oʻahu.

KPI 2. >70% of Referrals are Internal

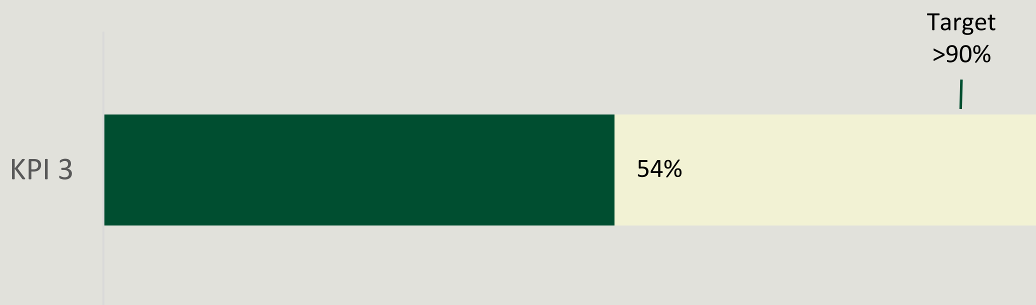
More than 70% of members potentially eligible for CIS were identified through Health Plan analytics and internal referrals.



Of the 257 potentially eligible ("newly referred") members identified during the quarter, 85 were referred internally (*n* = 9) or identified through internal analytics (*n* = 76). While not meeting the target of 70%, internal referrals made up the largest proportion of referral sources, followed closely by referrals from social services providers (31%) and medical providers (23%). Seven percent (7%) of referrals came from other health plans; 5% of referrals were missing source data; and 1% were from "other" sources.

KPI 3. Timely Eligibility Confirmation

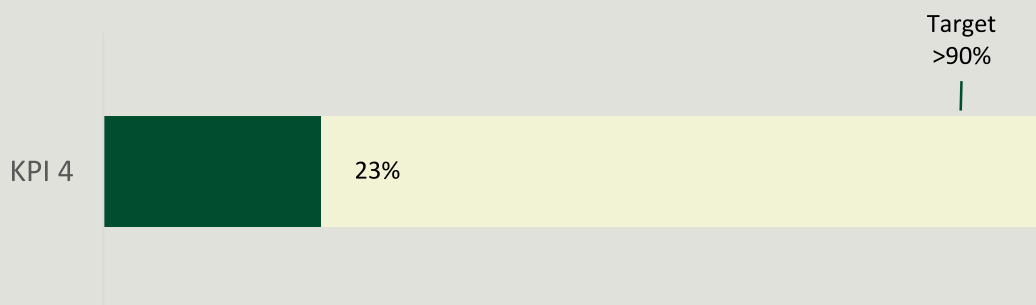
More than 90% of newly referred members had eligibility confirmation within the allowed window (15 days for external referrals; 30 days for internal referrals).



Of the 257 members newly referred this quarter, 144 members were confirmed eligible—139 of which were confirmed within the window (54% of all new referrals). This data suggests that when eligibility is confirmed, it is confirmed quickly and on time. However, it is unclear if members without eligibility confirmation data had yet to be confirmed or if they had been confirmed *ineligible*. Thus, it is possible that this metric could be higher if it included members who were confirmed *ineligible on time*. The revised reporting templates address this issue and will allow MQD to capture and assess length of time from referral to all eligibility determinations.

KPI 4. Timely Consent Process

More than 90% of newly confirmed eligible members were consented within 10 days of eligibility confirmation.

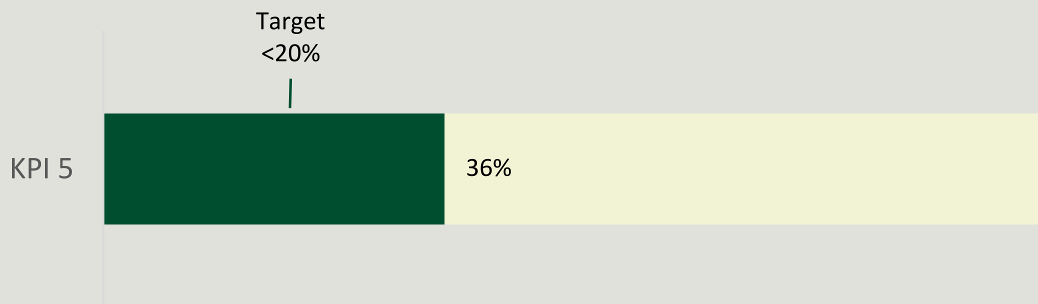


HPs confirmed 176 members eligible for CIS during the quarter. Of these 176 members, 50 had consented—40 within the 10-day window. Thus, 23% of newly eligible members were consented within 10 days of eligibility confirmation. Data suggests that of those members who had consented, most had been consented on time. However, of those members who had not yet consented (*n* = 126), 110 members were past the 10-day window. Sixteen had been confirmed eligible at the end of the quarter and were not yet past the window.

HPs were confused if KPIs 3 and 4 considered business or calendar days. MQD clarified calendar days in the new reporting templates and in the updated KPIs. CIS did not meet the targets for either business or calendar days in Q3.

KPI 5. <20% Decline to Participate

Less than 20% of newly eligible members declined participation in CIS.



Of the 176 members newly confirmed eligible during the quarter, HPs reported that 63 members had declined to participate in CIS. The evaluation team considered a "0" ("No") in the CONSENT field as a decline. However, it is possible some HPs entered a "0" for members who had not yet consented. The distinction between not yet consented and declining to participate is made clearer in the new reporting template.

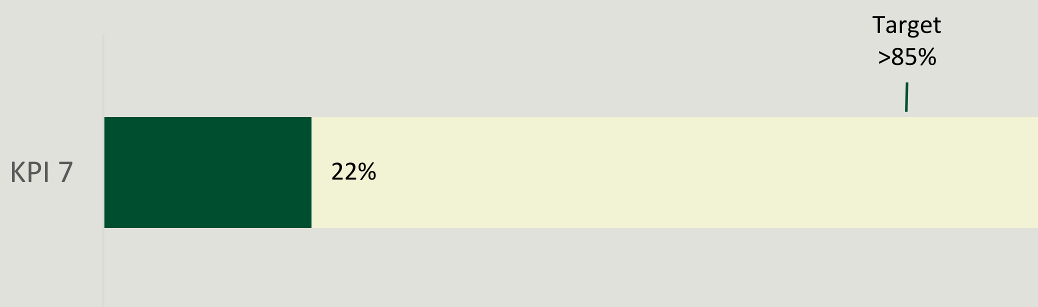
KPI 6. Timely Assessment

More than 90% of newly consented members completed an initial assessment within 15 days of consent.

Of the 58 newly consented members, 51 had completed an assessment–all within the 15-day window (88% of all newly consented members). Thus, CIS came close to meeting the 90% target. Given the recent reduction in assessment length, hopefully this metric will continue to improve.

KPI 7. Ongoing Re-Assessment

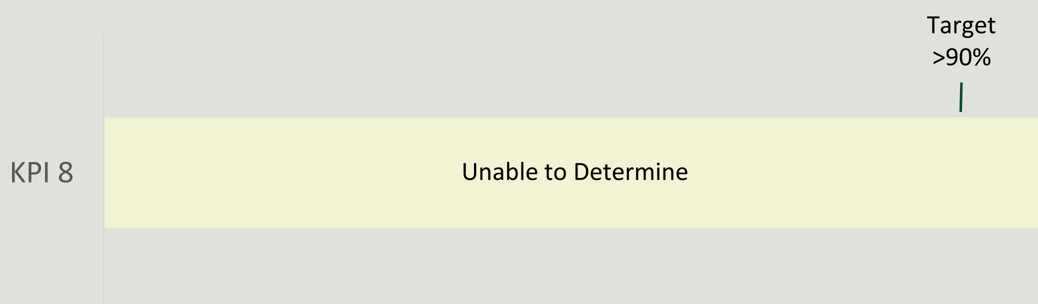
More than 85% of existing CIS members received a CIS Re-Assessment/Plan Review and Update within 90 days.



"Existing CIS members" include the 284 members who had consented in a previous quarter. Of these 284 existing members, 258 members had been assessed at some point. However, 222 had not completed an assessment or reassessment in over 90 days. Only 62 members (22% of existing members) were up to date on (re)assessments. Given the recent reduction in assessment and action plan length, hopefully this metric will improve.

KPI 8. High Medicaid Retention

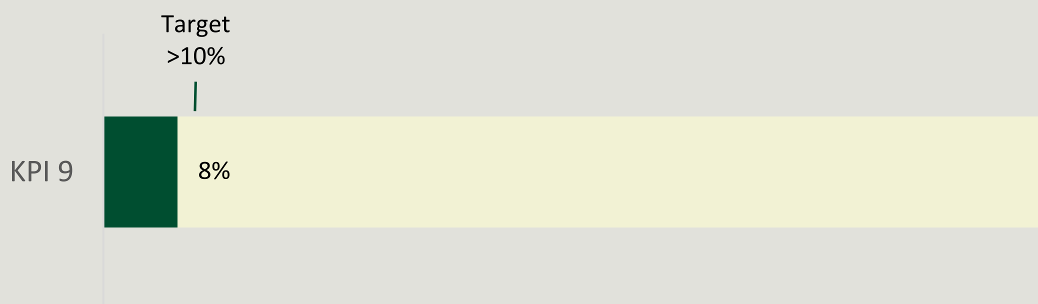
More than 90% of CIS members who were due for Medicaid eligibility re-determination remained in Medicaid on the last day of the reporting period.



The evaluation team was unable to determine progress toward this metric. Health Plans report this metric in aggregate (not at the individual level), and given the large numbers of "0s," it was unclear if HPs used 0 to indicate no members were due for re-determination and 0 remained in Medicaid or if this information was missing or unable to be determined. HPs continue to exhibit confusion over the difference between missing data, data that is not applicable, and data that is "0" for this metric and many other variables throughout the data report.

KPI 9. >10% Transition to Tenancy

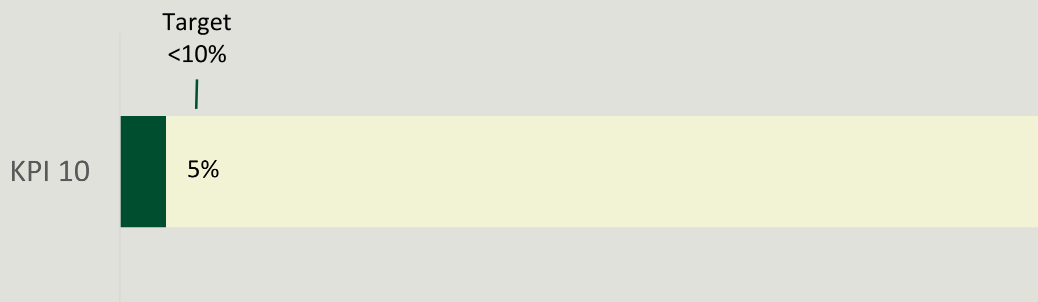
More than 10% of new and existing CIS members transitioned from pre-tenancy to tenancy.



Of the 342 members who had consented at any point (new and existing members), 27 members transitioned from tenancy to pre-tenancy as indicated by a “1” (“yes”) in the TRANSIT_TENANCY field. Thus, 8% of new and existing members transitioned from pre-tenancy to tenancy during the quarter. Notably, HPs indicated that 57 members transitioned from pre-tenancy to tenancy, but 30 of those members had not consented to participate in CIS nor had received assessments or presumably any services. Thus, these members were excluded from analysis for this metric.

KPI 10. <10% Lost to Follow up

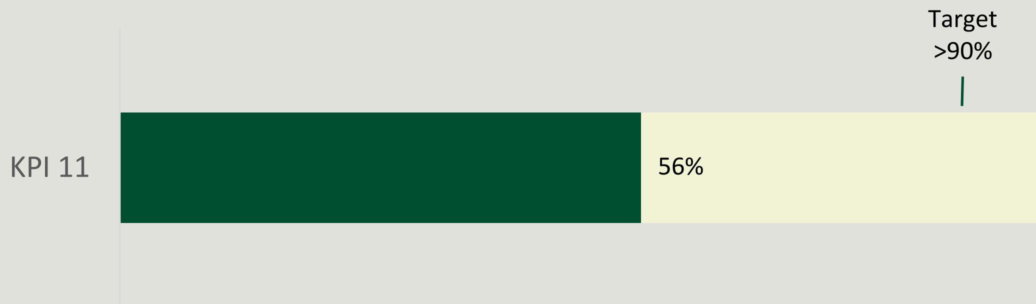
Less than 10% of new and existing CIS members were lost to follow up during the quarter.



Of the 342 members who consented at any point (new and existing members), 17 members disenrolled during the quarter—5 because they were lost to follow-up (approximately 1% of all new and existing members). However, 16 members ended the quarter in H7, the H code that indicates “lost to follow up.” Thus, we estimate that 5% of new and existing CIS members were lost to follow-up in Q3, which still meets the target of less than 10%.

KPI 11. >90% Assessments Shared with PCP

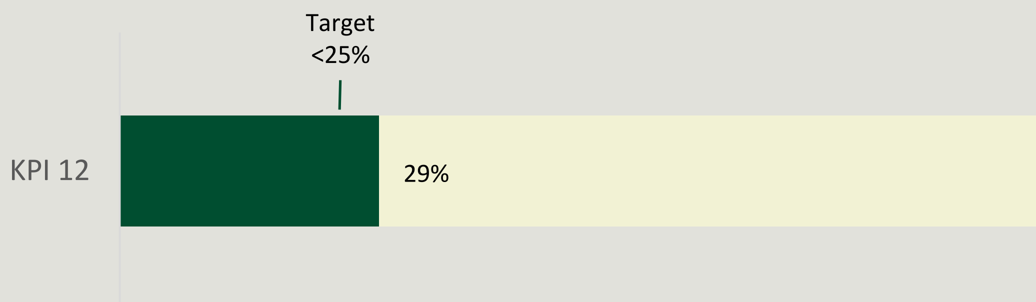
More than 90% of new and existing CIS members had Assessments/CIS Health Action Plan Addenda shared with their primary care physician (PCP).



HPs reported that 190 members of the 342 new and existing CIS members had had their assessment and health action plan data shared with their PCP. The remaining members had not had their data shared (*n* = 123) or had not yet been assessed (*n* = 29). Thus, 56% of new and existing CIS members had assessments shared with their PCP.

KPI 12. <25% without Yearly Check-ups

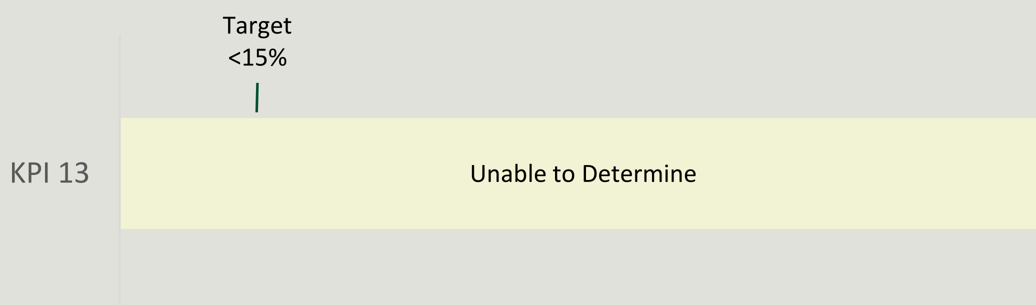
Less than 25% of new and existing CIS members have not had a routine check-up within the past year.



Of the 342 members who consented to CIS at any point (new and existing members), 240 members reported seeing their PCP in the last year at their last assessment. However, only 113 members had been assessed during the quarter, meaning data is inconclusive for the majority of new and existing members (67%; *n* = 229). **Given the large amounts of missing data and the rolling dates of assessments, this metric should be interpreted cautiously.** This metric is currently measured by self-reported assessment data, which will not be collected in the new reporting template. Therefore, the evaluation team will work with MQD to determine more reliable data sources, potentially claims and encounters data.

KPI 13. <15% with Hospitalizations

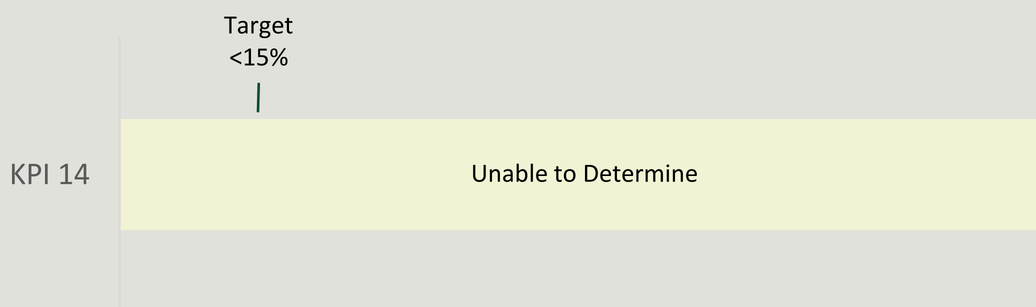
Less than15% of new and existing CIS members have two or more unplanned hospitalizations during the quarter.



Of the 342 members who consented at any point, 113 members were assessed during the quarter. Of these 113 members, 25 reported being hospitalized during the quarter. However, this data does not indicate the number of hospitalizations or provide information on whether or not they were unplanned. Given the large amount of missing data, we are unable to measure progress toward this metric.

KPI 14. <15% with ER Visits

Less than 15% of new and existing CIS members have two or more ER visits during the quarter.



Of the 342 members who consented at any point (new and existing members), 113 members were assessed during the quarter. Of these 113 members, 45 members reported going to the ER during the quarter—21 more than once. However, given the large amount of missing data (229 members with no current assessment data), we are unable to measure progress toward this metric.

For both KPI 13 and KPI 14, we would expect high rates of ER usage and unplanned hospitalizations for new CIS members, particularly because high emergency service utilizations is one of the indicators HPs use to identify members for CIS. Therefore, this KPI will be difficult to reach as defined. Additionally, these metrics are currently measured by self-reported assessment data, which will not be collected in the new reporting template. Therefore, the evaluation team will work with MQD to determine more reliable data sources, potentially claims and encounters data.

Assessment Data for 2023-Q3

During 2023-Q3, 33% (*n* = 113) of the 342 new and existing members completed an assessment or re-assessment. These 113 members had been enrolled in CIS for an average of 131 days at time of assessment. This section focuses on data collected from these assessments, particularly, member reported medical services usage (hospitalizations and ER visits), mental and physical health, services used and needed, and causes of their most recent homelessness.

Medical Service Usage

Of the 113 members who completed an assessment, 28% reported being admitted to the hospital during Q3.

Of assessed members, 49% reported going to the ER. Almost a quarter reported going to the ER more than one time during the quarter.

Unfortunately, no data exists for the other 229 members who were not assessed during the quarter.

Fig. 2. % of CIS Members Reporting Hospital Admissions in 2023-Q3

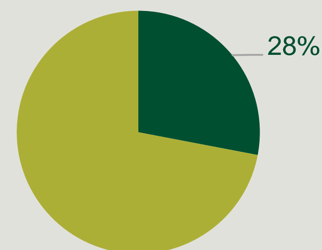


Fig. 3. % of CIS Members Reporting ER Visits in 2023-Q3

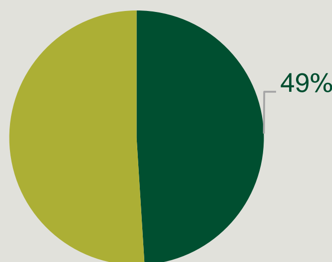
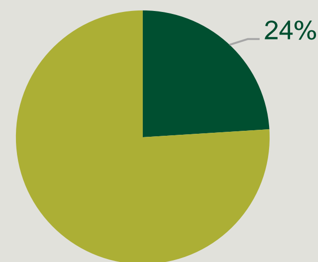


Fig. 4. % of CIS Members Reporting More than 1 ER Visit in 2023-Q3

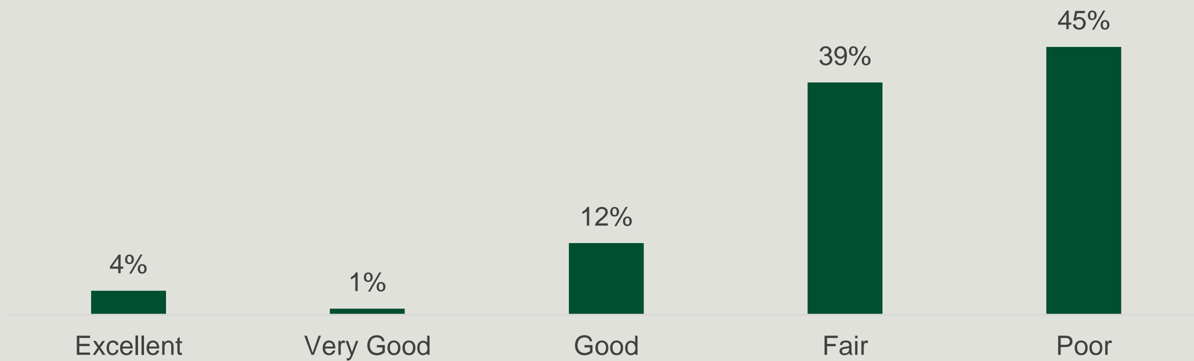


All figures exclude missing data (e.g., unanswered questions).

Mental and Physical Health

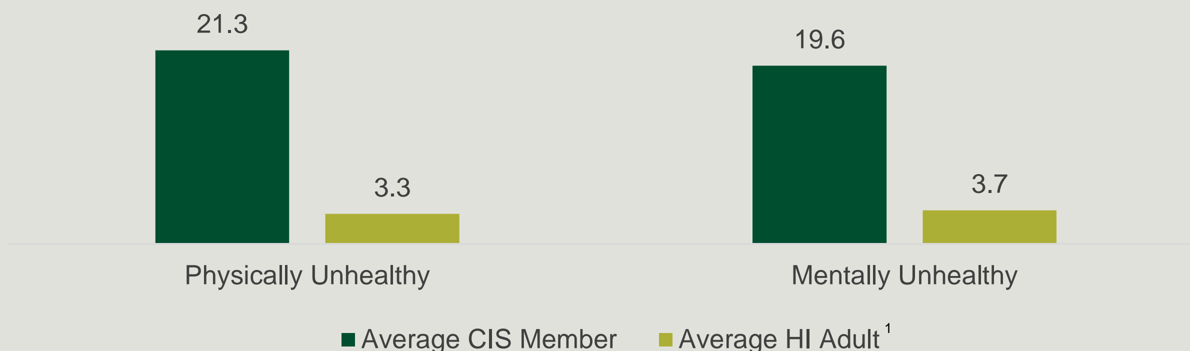
The evaluation team examined self-reported mental and physical health for the 113 new and existing CIS members who were assessed during the quarter. Measures include items from the CDC Healthy Days measure (USCDC, 2022), including a question asking about members' perceptions of their general health and two items asking members to indicate how many out of the last 30 days their mental and physical health have not been good, respectively.

Fig. 5. Percent of 2023-Q3 CIS Assessed Members Reporting that In General, their Health is....



Of the 113 members assessed during the quarter, the vast majority reported their general health to be "poor" (45%) or "fair" (39%). They also reported high numbers of physically unhealthy days during the quarter. The average number of physically unhealthy days in the last 30 days for CIS members was 21.3 days—more than 6 times the average number of physically unhealthy days reported by the average adult in Hawai'i. Similar trends were seen for the average number of self-reported mentally unhealthy days.

Fig. 6. Average Number of Unhealthy Days Reported in Last 30 Days for 2023-Q3 CIS Assessed Members



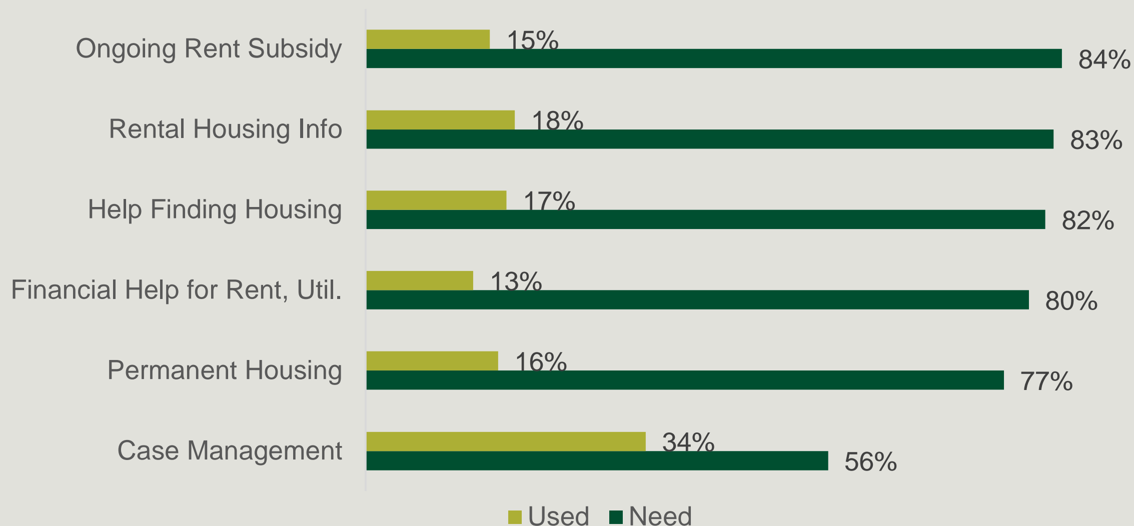
Taken together, data suggests that CIS members have poorer physical and mental health compared to the general population—even months after enrolling in CIS, suggesting that CIS is reaching the intended population and that health impacts will likely be long-term.

[1]U.S. Centers for Disease Control. (2022). Behavioral Risk Factor Surveillance System (BRFSS) 2022.

Services Used and Needed

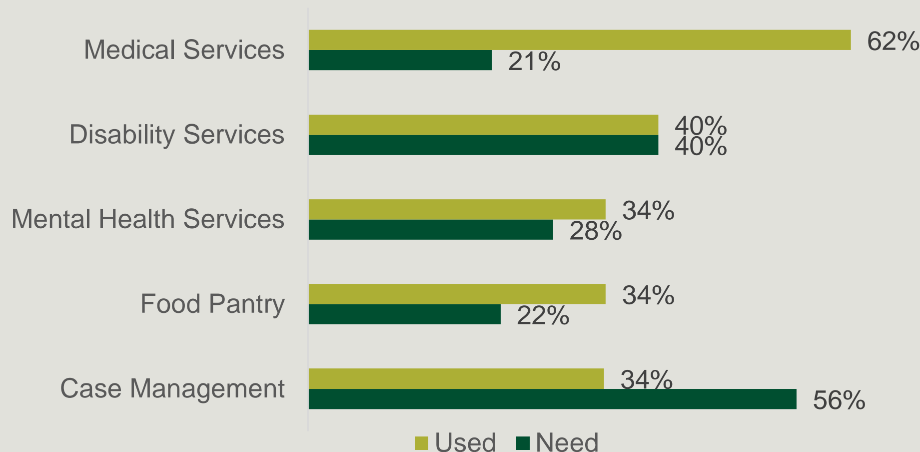
The services reported needed by the largest proportion of the 113 members assessed during the quarter were financial and housing-related services, with ongoing rental subsidy being needed by the most members (84%), followed by rental housing information (83%), help finding housing (82%), and financial assistance for rent and utilities (80%). Over half reported needing case management, with 34% reporting using the service during the quarter. Notably, a large gap exists between the percetage of members reporting using and needed each service, suggesting needs have yet to be met.

Fig. 7. Percentage of Q3 Assessed Members Reporting Needing and Using Each Service by Top 6 Most Frequently NEEDED Services



The service reported used by largest proportion of the 113 members assessed during the quarter included medical services (62%), followed by disability services (40%), mental health services (34%), food pantries (34%), and case management (34%). Notably, medical services was the only service for which a greater proprotion of members reported using it than reported needing it. Additionally, the same proportion of members reported using as needing disability services, suggesting these services were essential. Additional reported services used and needed can be found in Fig. 10 in the Appendix.

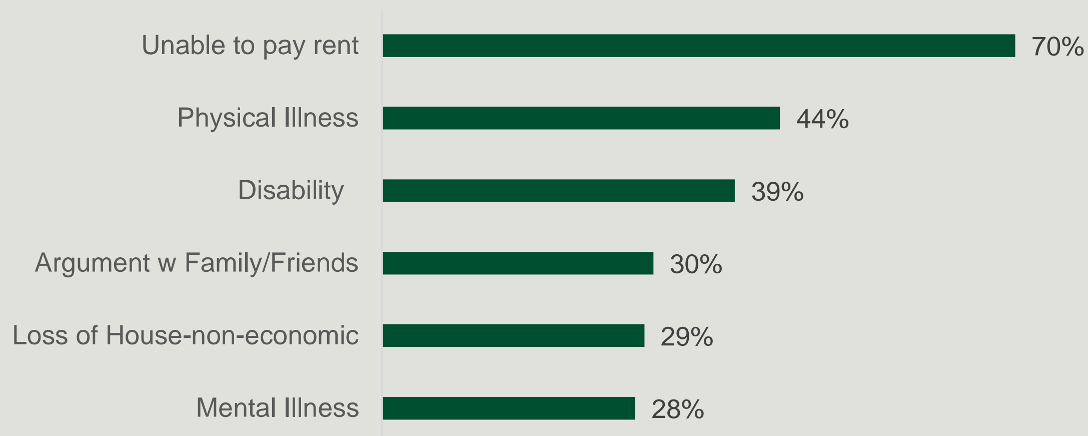
Fig. 8. Percentage of Q3 Assessed Members Reporting Needing and Using Each Service by Top 5 Most Frequently USED Services



Causes of Homelessness

The majority of the 113 CIS members assessed during the quarter (70%) reported that inability to pay rent was the cause of their most recent homelessness. Physical illness (44%) and disability (39%) were the next most frequently reported causes. Over a quarter of members reported argument with family/friends (30%), loss of house for non-economic reasons (29%), and mental illness (28%). Additional reported reasons can be found in Fig. 11 in the Appendix.

Fig. 9. % of Q3 Assessed Members Reporting Each Cause of Homelessness—Top 6 Causes



Summary

Inconclusive CIS Numbers

In general, large descrepancies existed between the number of members HPs reported to be enrolled in CIS (*n* = 342), members HPs reported to be enrolled and receiving services (*n* = 832), and the number of members with encounters (*n* = 46) submitted by HPs during the quarter. These descrepancies make it difficult to determine how many members received CIS during the quarter and subsequently, to accurately measure progress towards KPIs and to determine program impact on member health and housing outcomes.

Marginal Progress toward KPIs

Despite these descrepancies, the evaluation team was able tentatively to assess progress toward KPIs established by MQD. CIS met two of the 14 KPIs, including:

- establishing data sharing agreements between HPs and HMIS (KPI 1) and
- maintaining a low rate of enrolled CIS members lost to follow up (KPI 10).

Despite meeting KPI 1, HPs did note that they have only been able to establish data sharing with and access to the O'ahu Continuum of Care's (CoC) HMIS, noting the lack of participation of the neighborhing island CoC's HMIS has been a barrier to care coordination. This quarter CIS made progress on two additional KPIs, coming close to meeting the targets. For example, 88% (target >90%) of members were assessed within 15 days of consent, and 71% (target 75%) had had a routine check-up within the last year.

While progress towards KPIs is marginal, the new reporting template, reduced length of forms, and other reporting improvements have gone into effect since Q3. Made in response to challenges reflected in RCAs, these improvements will make it easier to track KPI progress as well as will help reduce barriers that have impeded progress toward KPIs.

CIS Members Experience Poor Health

Based on assessments conducted during 2023-Q3, data we are able to provide a snapshot description of assessed CIS members during the quarter. Data suggests that these members:

- have high rates of emergency services utilization
- report significantly poor physical health
- were likely to be experiencing homeless due to inability to pay rent & physical illness.

At assessment, members had been enrolled in CIS 131 days on average, suggesting that health improvements will likely be long-term in nature. Therefore, it will be essential for HPs and HSPs to conduct quarterly re-assessments to determine program impact over time on member health and well-being.

CIS Member Needs Are Primarily Financial

Data suggests that CIS members primarily need financial services, particularly rental subsidies & other financial assistance to cover housing and utilities. In general, the services CIS members reported needing largely reflect reported causes of homelessness and are financial in nature. For example, the largest proportion of CIS members reported needing ongoing rental subsidies (84%) and reported inability to pay rent to be the cause of their homelessness (70%).

However, a large proportion reported loss of housing for non-economic reasons and argument with friends or family as the caused of their homelessness, reflecting local data trends that people in Hawaiʻi are more likely to fall into homelessness due to a break up of family than people on the continent (PIT, 2023).

Most CIS Members Accessed Medical Services

The majority of CIS members reported using medical services during the quarter, suggesting that CIS is reconnecting members to health services. Additionally, case management services were reported both used and needed by large proportions of members, suggesting the importance of case management for CIS members.

Data Quality Issues Improve but Continue

Data quality has improved drastically over the past three years; however, data is still subpar as the evaluation team is still **unable to determine how many people received CIS during a given quarter**. Particular data issues include the fact that HPs continue to misunderstand the difference between missing data, data that is not applicable, and the number “0”. Additionally, some fields in the member-level data file are often contradictory. For example, some members are flagged as ending the quarter in H7 (“lost to follow up”) but are not flagged as disenrolled in the program. Also, some members who have not been consented or confirmed eligible are flagged as receiving tenancy or pre-tenancy.

In addition to contradictory data, some HPs continue to use the wrong report templates, to not use the data validation template, and to change cell formats within the template. Because of these issues, merging data across HPs is arduous and time consuming, making it difficult for the evaluation team to meet the RCA time requirements.

Finally, because of lack of ongoing assessment data, we are **unable to determine individual member progress over time—in other words, program impact.** It is imperative that HPs work with MQD, HSPs, PCG and the evaluation team to improve data quality in order to determine how many people have received CIS, what they need, & how they fare while in the program.

Recommendations

Based on findings, the evaluation team makes the following recommendations for MQD:

Encourage Bridging the Gap to Provide HMIS Access

Leverage MQD partnerships with Bridging the Gap partners, health care providers, and HSP leaders on neighboring islands to encourage HMIS access for HPs.

Revisit and Revise KPIs and KPI Benchmarks

MQD revisit and revise KPIs and KPI benchmarks to reflect current context and implementation stage. In particular,

- KPI 2: >70% of referrals are internal–Depending on the original intention, MQD may want to consider removing this KPI or revising the benchmark. Internal referrals do comprise the largest proportion of referrals currently. However, it is unclear why these referrals are preferable to other referrals sources. Given that the number of referrals from any source outweighs the capacity of HSPs to provide services, this KPI may not be relevant to program progress.
- KPI 3: >90% with eligibility confirmation within window– Revise KPI wording to include all eligibility determinations, including members determined ineligible. Omit members referred within 30 days from the end of the quarter from the denominator.
- KPI 4: >90% consented within 10-day window—Omit members who were consented within 10 days from the end of the quarter from the denominator.
- KPI13 & KPI14: <15% with unplanned hospitalizations/ER visits—Because of the extreme medical fragility of CIS members, this target may be unrealistic. Additionally, health impacts usually take months or years to occur and even longer to detect. Because enrollment is on a rolling basis, members will have been in the program for varying amounts of time. These impacts are also usually dependent upon a member first achieving housing. Thus, it may be worthwhile to consider having different benchmarks for members in tenancy versus pre-tenancy or for members who have been enrolled for varying amounts of times. At the very least, new members should be omitted from the denominator.

Reject Submissions with Significant Data Concerns

Given that the data issues have persisted despite requested improvements to the reporting templates and technical assistance from PCG, the evaluation team suggests that the next reporting cycle would be an appropriate time to start rejecting report submissions that have significant data concerns. Significant concerns include contradicting data (as

described previously in this report) such that the number of members served is impossible to determine, use of incorrect templates, and/or changing formats of the template or cells in the template.

Resume Technical Assistance

To aid HPs in preparing report submissions of high quality, the evaluation team suggests that MQD resume its technical assistance (TA) for CIS reports. Additionally, TA through PCG would be helpful for HPs who must resubmit a rejected report submission.

Emphasize Reassessments

Because longitudinal data is essential to assessing program impacts, we suggest that HSPs, HPs, and MQD emphasize the importance of reassessments. Recent reductions in length of forms is a good step toward encouraging both administering of reassessments and reporting reassessment data.

Rental Subsidies

Given that the most needed service was rental subsidy assistance, consider working with the homelessness service system to pair CIS with existing voucher programs. Additionally, consider how the new waiver benefits that can provide rental assistance can fit into the existing CIS program and the overall homelessness service system.

Focus on Homeless Prevention

CIS in its current implementation (housing navigation only) may be best suited for members who are at-risk for homelessness or newly homeless. Given that most CIS members reported needing rental subsidies and CIS does not yet provide rental assistance, it may be useful to target people who need assistance navigating a new service landscape but not as much intensive financial assistance. Current HUD Homeless Prevention programs have burdensome eligibility requirements that make it difficult for providers to implement. CIS may be a useful workaround.

Reconsider Eligibility Requirements Given Local Data

Given the local context, it is worth considering eligibility requirements through a local lens. For example, as mentioned above, some federal programs are difficult to implement locally because of arduous eligibility requirements (e.g., a written eviction notice) that put undue burden on certain groups, like Pacific Islanders, who are less likely to be able to obtain an eviction notice (because they are less likely to be renting from a landlord and are more likely to be living with friends or family). Given the flexibility of the 1115 Waiver, we encourage MQD to consider how it may be used to bridge some of the gaps created by eligibility requirements of less-flexible programs within the homelessness service system.

Consider Using Self-Reported Causes and Needs for Prioritization

Given that causes of homelessness tend to reflect service needs (Barile et al., 2020), for future iterations of CIS, with multiple types of services, consider using member reported causes of homelessness to help match and prioritize them for types of CIS and services.

Appendix

A. References

B. Additional Assessment Data

C. Key Performance Indicators

A. References

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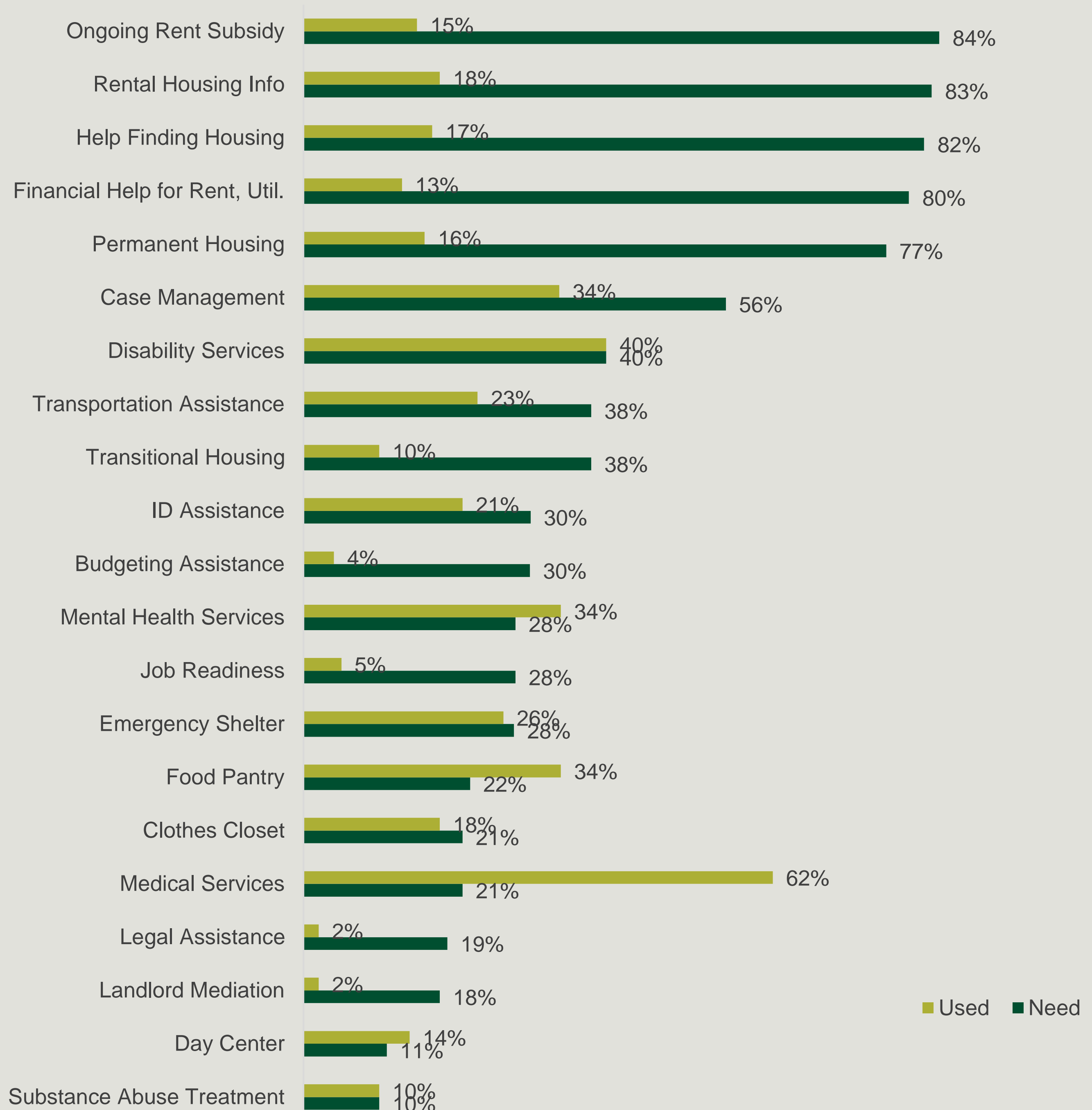
B. Additional Assessment Data



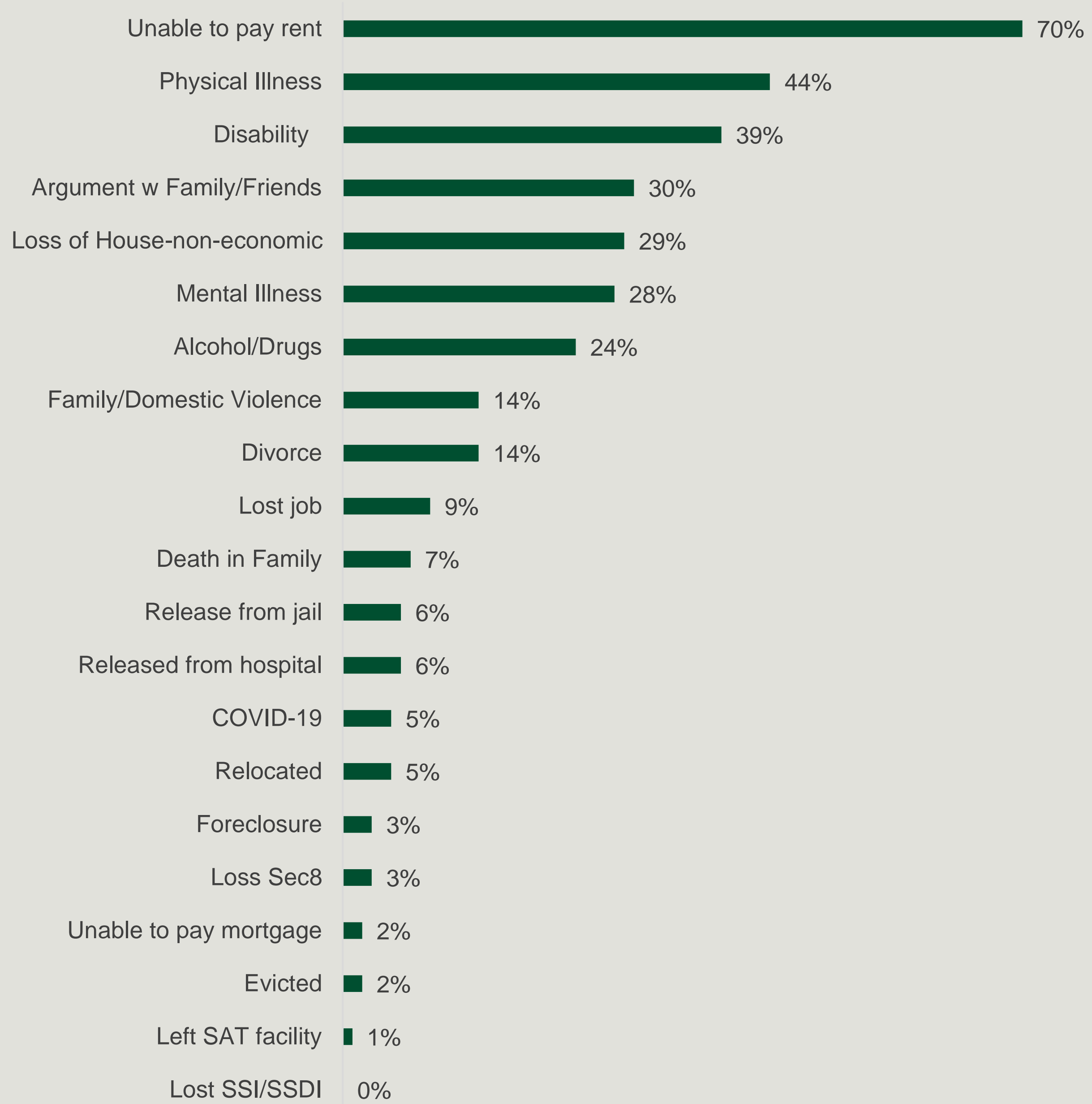


Fig. 11. Percent of Q3 Assessed Members Reporting Each Cause of Homelessness
Unable to pay rent
70%
Physical Illness
44%
Disability
39%
Argument w Family/Friends
30%
Loss of House-non-economic
29%
Mental Illness
28%
Alcohol/Drugs
24%
Family/Domestic Violence
14%
Divorce
14%
Lost job
9%
Death in Family
7%
Release from jail
6%
Released from hospital
6%
COVID-19
5%
Relocated
5%
Foreclosure
3%
Loss Sec8
3%
Unable to pay mortgage
2%
Evicted
2%
Left SAT facility
1%
Lost SSI/SSDI
0%

C. Key Performance Indicators

Original KPIs

1. The Health Plan has an active and ongoing data exchange process and/or data sharing agreement with the Homeless Information Management System (HMIS) and/or the Coordinated Entry System (CES) to identify members who are potentially eligible for CIS, and/or track CIS members' prioritization for housing supports.
2. Percent of members potentially eligible for CIS identified through Health Plan analytics and internal referrals.
3. Percent of members with eligibility confirmation within the allowed window (15 days for external referrals; 30 days for internal referrals).
4. Percent of members who consented to participate in CIS within 10 days of eligibility confirmation.
5. Percent of members who declined participation in CIS.
6. Percent of new CIS members who completed their initial assessment within 15 days of consent.
7. Percent of existing CIS members who received a CIS Re-Assessment/Plan Review and Update within 90 days.
8. Percent of CIS members who were due for Medicaid eligibility re-determination who remained in Medicaid on the last day of the reporting period.
9. Percent of CIS members who transitioned from pre-tenancy to tenancy.
10. Percent of CIS members who were lost to follow up.
11. Percent of CIS members whose Assessments/CIS Health Action Addenda were shared with their PCP.
12. 12. Percent of CIS members who have not had a routine check-up within the past year.
13. 13. Percent of CIS members with two or more unplanned hospitalizations.
14. 14. Percent of CIS members with two or more ER Visits.

Found in Health Plan Manual Part III Reporting Guide, Section 201.5, pg. 90-91 released on April 14, 2021.

Updated KPIs from October 1st 2023

1. The Health Plan has an active and ongoing data exchange process and/or data sharing agreement with the Homeless Information Management System (HMIS) and/or the Coordinated Entry System (CES) to identify members who are potentially eligible for CIS, and/or track CIS members' prioritization for housing supports.
2. Health Plan has completed 100% of fields for members who consented over 75 calendar days prior to report submission.
3. % members potentially eligible for CIS identified through Health Plan analytics and internal referrals
4. % members with eligibility confirmation within the allowed window (30 calendar days for external referrals and internal referrals)
5. % members who consented to participate in CIS within 10 calendar days of eligibility confirmation
6. % members who declined participation in CIS
7. % new CIS members who completed their initial assessment within 45 calendar days of consent
8. % existing CIS members who received a CIS ReAssessment/Plan Review and Update within 90 calendar days of previous Action Plan
9. % CIS members who were due for Medicaid eligibility redetermination who remained in Medicaid on the last day of the reporting period
10. % of CIS members who transitioned from pre-tenancy to tenancy during the quarter
11. % of CIS members who were lost to follow up during the quarter
12. % of CIS members whose Assessments / CIS Action Plans were shared with their PCP during the quarter
13. % of CIS members with two or more hospitalizations in past 3 months
14. % of CIS members with two or more ER Visits in past 3 months

Found in Health Plan Manual Part III Reporting Guide, Section 201.5, pg. 81-82 released on October 1, 2023.