Shared Metrics Data Validation Narrative *Total Points: 15 Points*	**PRE-Submission: Aug 15, 2019** **FINAL-Submission: Sept 30, 2019**
Health Plan:	**Mid-State Health Network, PIHP Region 5**
Date:	**September 30, 2019**

Instructions for Submission:

1) Please complete the form by clicking on the text or option boxes and entering your answers

2) Naming convention to use when sending submissions to the FTP site:
   - Pre-Submission: <MHP/PIHP Acronym> 2019 Data Validation Narrative PRE
   - Final Submissions: <MHP/PIHP Acronym> 2019 Data Validation Narrative FINAL

If you have any questions, please contact:
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FY2019 Shared Metrics Data Validation Narrative

During FY2019, Medicaid Health Plans (MHPs) and Prepaid Inpatient Health Plans (PIHPs) had the opportunity to review and validate measure data for two performance measures: Plan All-Cause Readmissions (PCR) and Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA). Event-level data was provided by MDHHS for both measures for the 6/30/18 measurement period. The purpose of the Shared Metrics Data Validation Narrative is to demonstrate participation in these validation activities and to submit a report (up to four pages) on findings of efforts to review and validate data, noting discrepancies found that impact the measure results, as well as actions taken to address data issues (as needed). Complete all sections below.

Plan All-Cause Readmissions (PCR)

Event-level detail was provided to health plans for PCR via CC360. MHPs and PIHPs were to review and validate this measure data against their own data systems for both numerator and denominator results. Please answer both questions in the Plan All-Cause Readmissions (PCR) section. These questions are worth 10 points in total.

1. What did you find in the data? Describe any discrepancies found between health plan and MDHHS data for this measure, such as: dates of service differences (ex. last billing date versus discharge date); claims or provider specialty changes results; exclusion applicability (ex. hospice); and eligibility discrepancies (ex. change in health plan during measurement period).

When performing data validation for this measure, MSHN focused on validating the numerator events (ie: those individuals who were flagged as having a hospital re-admission within 30 days). The PCR raw data extract from CC360 included 1833 "NO" numerator result flags out of 12058 total records. MSHN cross-matched the 1833 numerator events with a similar PCR report from its population health data analytics program, Integrated Care Delivery Platform (ICDP) by Zenith Technology Solutions. The cross-matched report from ICDP resulted in 1562 "NO" numerator result flags and 268 "YES" numerator results flags, a difference of 268 records where the MSHN numerator result flag was "YES" and MDHHS result flag was "NO." Further analysis of these 268 records resulted in 3 primary areas of discrepancy (described below). For the 268 records in which numerator discrepancy was noted, one of the following 3 reasons was listed in Column AA of MSHN's data validation submission to MDHHS:

Greater Than 30 Days: The individual had a hospital readmission but it was greater than 30 days from the initial hospitalization event according to MSHN records (52 records)

Next Day Transfer: The individual was transferred the day after admission which may have been incorrectly counted as a qualifying readmission in the MDHHS data set (4 records)

No Qualifying Readmit in Timeframe: MSHN data did not show any qualifying readmission within 30 days of the initial hospitalization event (214 records)

Plan All-Cause Readmissions (PCR)

2. How can performance be improved? Describe current strategies to improve performance on this measure, including utilizing ADTs or other forms of secure data exchange to coordinate care for patients. Identify goals, objectives and activities for improving performance on this measure, including coordination with partner plans.

MSHN has been monitoring the PCR measure as part of its regional performance measurement portfolio for the last 3 years. As such, MSHN and its CMHSP member organizations have implemented a variety of strategies to improve performance on this measure and enhance coordination of care for individuals served.

Use of ADTs and other Data: Each CMHSP in the MSHN region utilizes the population health data analytics program Integrated Care Delivery Platform (ICDP) by Zenith Technology Solutions. ICDP includes actionable ADT alerts which are generated for case managers at each CMHSP for their specific caseload. Case managers receive a care alert that an individual on their caseload has been admitted to the hospital and then they are expected to initiate outreach to the individual, preferably prior to discharge, in order to assess what additional supports the person may need upon discharge. By assessing and addressing needs such as transportation to follow-up appointments and access to pharmacy to fill necessary medications, case managers play an important role in helping reduce risk factors that lead to readmission. ICDP also includes a PCR performance report which is updated monthly and available to each CMHSP. The regional utilization management committee (comprised of utilization management directors from each of the 12 CMHSPs in region 5 and MSHN's Director of Utilization & Care Management) reviews the PCR performance report quarterly and recommends action when individual CMHSP performance or regional performance rises above the benchmark rate of 15% (based on national Medicare/Medicaid plan all-cause readmission rate averages). For example, a CMHSP data analysis of all cases of readmission during FY19 Q1 resulted in a finding that 69% of readmission cases resulted from one hospital. In the majority of cases, it was determined that discharge planning was not adequate. The CMHSP engaged in a series of meetings with hospital administrators and developed a new discharge planning process which was implemented during FY19 Q3-Q4. It is anticipated that this will result in reduced rates of recidivism, which will be monitored and evaluated during FY20. Each CMHSP also gets a dataset of every ADT that comes through everyday that they can use integrated into their EMR. This allows for ADT lists to show up in their workflow where they can act on them and identify what action was taken to coordinate care. We are actively working with MiHIN to receive Medication Reconciliation records to support the ADT workflow process.

Clinical Protocols & Care Coordination: CMHSPs have implemented local clinical protocols such as monthly or weekly multidisciplinary complex care meetings to develop plans of care for individuals at high-risk for hospital readmission. Plans of care include coordination among various providers involved in the individual's care (physical and behavioral health) and addressing identified Social Determinants of Health that could lead to readmission.

Coordination with Partner Plans: During FY19 MSHN participated in a workgroup composed of representatives from 4 PIHPs and 3 MHPs with the goal of developing a statewide clinical protocol to be used by all PIHPs and MHPs to address this measure. Activities of this workgroup included an extensive literature review of national and state data related to risk factors for hospital readmission and development of risk stratification criteria to assist plans in identifying those members with highest levels of risk in order to initiate additional care management interventions. Key findings of this workgroup included the following:

- Presence of a substance use disorder is one of the highest risk factors for hospital readmission
- Risk of readmission is positively correlated with the number of chronic conditions a person experiences (specific diagnoses identified in research as some of the highest-risk include schizophrenia, bipolar disorder, renal disease, chronic obstructive pulmonary disease, and diabetes)
- Shorter length of stay for psychiatric inpatient hospitalization is correlated with higher risk of readmission; conversely, longer length of stay for physical health inpatient hospitalization is correlated with higher risk of readmission
- Number of emergency room visits in the 6 months prior to the initial hospital admission is positively correlated with a higher risk of readmission

Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

Event-level detail for FUA was provided to health plans via FTP on March 14, 2019. MHPs and PIHPs received denominator events only.

MHPs were to review denominator events against their own emergency department claims. MHPs were also to document any members who received numerator compliant follow-up services.

PIHPs were to document any members who received numerator compliant follow-up services.

Please answer all three questions in the Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA) section. These questions are worth 5 points in total.

1. What did you find in the data? Describe any discrepancies found between health plan and MDHHS data for this measure, such as: dates of service differences (ex. last billing date versus discharge date); claims or provider specialty changes results; exclusion applicability (ex. hospice); and eligibility discrepancies (ex. change in health plan during measurement period).

The original Mid-State FUA Event Detail extract provided by MDHHS contained records for 2178 events. When performing numerator validation activities MSHN filtered out all results of individuals for whom their Medicaid Health Plan was listed as "Null" (presumably Fee For Service/State of Michigan). This was due to a mistaken belief on MSHN's part that the numerator data was being validated for joint performance for individuals enrolled with Medicaid Health Plans only. The resulting MSHN data validation submission to MDHHS after filtering out numerator events for Fee For Service beneficiaries was 262/2178 (12.02%).

Since MSHN submitted its data validation to MDHHS in June, additional numerator data validation activities were performed including the Fee For Service beneficiaries that had previously been filtered out. This yielded a numerator of 316/2178 (14.50%).

According to the CC360 performance report for the period ending on 6/30/2018, MSHN's performance was 543/2558 (21.23%). Since the data extract provided by MDHHS contained only 2178 event records, there is a difference of 380 additional consumer-level events in the denominator. Presumably these individuals were enrolled with MSHN PIHP at the time of the event (ED visit) but were no longer enrolled with MSHN PIHP at the time of data validation activities. It is difficult to calculate a true match rate since the data provided for validation is different than the data included in the measurement period calculation by MDHHS.

Follow-up after Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)

2. What did you learn about disparities from the data? Describe analysis of the FUA rate and data that you have done. Specifically, describe review by: Race/Ethnicity (REQUIRED), Age, Gender, Providers, Geography, and/or Other.

Figure 1: MSHN region FUA by race/ethnicity:

Race/Ethnicity	Percentage of all ED Visits	FUA Percent
African American	16%	6.08%
White	70%	15.60%
American Indian/Alaskan Native	1%	12.50%
Asian American	0%	0%
Hispanic	6%	16.60%
Native Hawaiian/ Pacific Islander	0%	0%
Unknown	6%	12.60%

Figure 2: MSHN region FUA by gender:

Gender	Percentage of all ED Visits	FUA Percent
Female	36.40%	13.87%
Male	63.59%	11.04%

Figure 3: MSHN region FUA by age:

Age	Percentage of All ED Visits	Total FUA Rate
13-19	4%	3.90%
20-26	12.21%	10.18%
27-35	26.90%	15.87%
36-45	20%	15%
46-55	23.23%	10.47%
56-65	13%	8%

In addition to analyzing the FUA data by age, race, and gender as depicted above, MSHN also analyzed the data by performance rate for each of the 21 counties in its region. Performance rates by county ranged from 0% to as high as 38% during the reporting period. MSHN will use

the county performance data combined with the age, race, and gender data to develop strategies aimed at addressing the most significant disparities. For example, 77% of the ED visits by African American individuals occurred in 3 counties in the MSHN region- Saginaw, Ingham, and Jackson. By identifying the counties and specific hospital ERs being used by a large percent of African American individuals, MSHN and its provider network can implement strategies to increase engagement such as enhancing the presence of peer support specialists in these specific hospital ERs.

3. How can performance be improved? Describe current strategies to improve performance on this measure, including utilizing ADTs or other forms of secure data exchange in care coordination for patients. Describe how your health plan is monitoring ED utilization for alcohol and other drugs and what has been done to improve communication regarding ED visits for alcohol and other drugs. If not using ADTs, or if you have not taken other steps, explain why not and plans for the future. Identify goals, objectives and activities for improving performance on this measure, including coordination with partner plans.

During FY19 MSHN developed an internal task force and FUA action plan with targeted strategies to improve performance on the FUA measure. The MSHN FUA task force has held monthly meetings throughout FY19 in order to provide regular updates regarding progress toward work plan objectives. Specific objectives of the workplan include:

Meetings with Hospitals- MSHN is in the process of scheduling meetings with administrators of each hospital emergency room in its 21-county region. These meetings will also include key personnel from the local Community Mental Health organization for the county where the hospital is located. The purpose of each meeting is to develop a local strategy for use of SBIRT or Project ASSERT practices and peer recovery coaches in the ER (where they do not already exist), and to clarify the referral pathway from the ER to the appropriate behavioral health and SUD treatment resources. This will allow MSHN and its network of service providers to hopefully intervene with at-risk individuals prior to them being discharged from the ER so that key demographic data and contact information can be gathered in order to perform outreach and follow up for referrals.

Use of ADTs by SUD Service Providers (SUDSPs)- Currently all CMHSPs in the MSHN region have access to ADTs and monitor ED utilization for the individuals they serve however most SUDSPs do not currently have access to or use ADTs. MSHN is currently working to make ADTs available to SUDSPs through the PIHP electronic managed care system. This will allow SUDSPs to receive ADT alerts for individuals who are currently admitted to their program. MSHN will

conduct regional training for SUDSPs educating them regarding how to incorporate the use of ADTs in their clinical workflow practices and expectations regarding follow-up activities.

Accurate Encounter Reporting for Follow-Up Services- As a result of data validation activities for this measure MSHN identified that in many cases valid follow-up services are being provided however due to the way some of these services are financed (ie: via SUD prevention funding) they are not being reported as treatment encounters. Aggregate data is collected regarding total numbers served, but individual beneficiary treatment encounters are not currently submitted. Throughout FY19 MSHN has worked on strategies to transition funding and reporting for these services from SUD prevention funding with aggregate data reporting to SUD treatment funding with individual beneficiary encounter reporting.

Monthly MHP/PIHP Care Coordination Meetings- In addition to identifying mutual members for care coordination via the CC360 risk stratification tool, MSHN and many of its MHP partners have begun monitoring ADT feeds for ED visits related to alcohol and other drugs and discussing identified individuals in monthly care coordination meetings. This has resulted in coordinated efforts around which entity will take primary responsibility for performing outreach to the member and facilitate referrals to appropriate follow up services.

Initiation of Medication-Assisted Treatment (MAT) in the ED- MSHN is also exploring opportunities to partner with current contracted MAT providers and hospital EDs that have higher volumes of AOD-related visits in order to initiate MAT services where appropriate in the ED. The ED physician would begin medication induction at the time of the ED visit and then conduct a warm-handoff to the MSHN-contracted MAT provider for continuing care.

Proposed process for FY20 PRC and FUA Data Validation Activities

4. FY20 Subgroups: MDHHS is planning to form subgroups for the FY20 PCR and FUA data validation activities. Each subgroup would include at least one MHP and one PIHP representative. Please provide feedback on your thoughts for this approach and any recommendations you have:

MSHN supports this approach with the recommendation that MDHHS recommend PIHP and MHP member appointment on each subgroup based on performance. It would be helpful for each subgroup to be comprised of representatives from plans that are performing strongly as well as plans that have room for improvement in order to facilitate learning and adopt best practices from plans that are performing strongly. Additionally, existing workgroups should be leveraged or combined in order to avoid duplication of effort and potential confusion. For

example, the PIHP/MHP integrated health workgroup (facilitated by Joe Sedlock and Laurie Salswadel) has an existing PCR subgroup comprised of both PIHP and MHP members. This subgroup is currently working on developing a shared care coordination protocol for MHPs and PIHPs that would include elements such as:

- Establishing which entity (MHP/PIHP) has primary responsibility for initiating follow-up and risk screening for individuals following discharge from an inpatient hospital stay
- Identifying a standard screening instrument (such as LACE) for assessing risk for readmission

MSHN is willing and interested in subgroup participation as determined by MDHHS.