

# **BHI Annual Quality Report**

Fiscal Year 2013

## **Quality Improvement Department**

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## Executive Summary

Behavioral Healthcare, Inc.'s (BHI) Quality Improvement (QI) Program is modeled after the Total Quality Management (TQM) System. This model allows BHI departments the sharing of knowledge to provide multidimensional health care management and incorporate business intelligence into programmatic decision-making. BHI departments work collaboratively to implement and maintain a continuous process of quality assessment, measurement, intervention, and re-measurement of service and outcome related measures.

The QI program at BHI has demonstrated a great deal of progress in FY13. The QI program is committed to continued growth and development of additional measurement, metrics, and data-driven quality improvement projects. Overall, the success and initiatives of the QI program meet the quality improvement needs of BHI.

This report represents a summary of program activities accomplished during the contract Fiscal Year 2013 (FY13) - July 1, 2012 through June 30, 2013. Below is a summary of key metrics, key accomplishments for FY13, and key initiatives for FY14.

### Key Metric Trends

Measure	Goal	FY11	FY12	FY13
Access to Care				
• Routine Care within 7 days	100.00%	99.73%	99.83%	99.84%
• Urgent Care within 24 hours	100.00%	100.00%	100.00%	100.00%
• Emergent Care within 1 hour	100.00%	99.46%	100.00%	100.00%
• Emergency Phone Calls	100.00%	100.00%	100.00%	100.00%
Access to Medication Evaluations				
• Adult	90.00%	Data	88.44%	88.25%
• Children	90.00%	Unavailable	87.61%	88.83%
Penetration Rates				
• Total Rate	>13%	10.46%	11.28%	*
Utilization Monitoring				
• Inpatient: Admits per 1000 members		3.26	2.87	*
• Inpatient: Average length of stay		7.80	7.13	*
• Emergency room visits per 1000 members		6.64	9.95	*
Follow-up After Hospital Discharge				
• 7 Days	90.00%	51.01%	59.31%	63.06%**
• 30 Days	95.00%	67.45%	72.70%	79.62%**
Inpatient Readmits				
• 7 Days		4.13%	2.95%	*
• 30 Days		12.56%	8.84%	*
• 90 Days		19.45%	15.08%	*

\*Data will be available upon validation of FY13 Performance Measures

\*\*Data based on the average of FY13 Quarter 1, 2, and 3 data.

## Key Accomplishments from FY13

Project	Accomplishment
Network Adequacy	Implemented Geo-Coding project to better assess geographic needs of members and geographic layout of providers
EQRO	Achieved overall EQRO compliance score of 96%
Provider Audits	Refined audit process, initiated 10 provider compliance audits, and developed documentation training materials
Encounter Data Validation Audit	Achieved near-perfect inter-rater reliability with HSAG
Patient Tools	Implemented Patient Tools system with BHI Drop-in Centers to meet documentation requirements for Drop-in Center encounters
USCS Manual	Played integral role in revisions and editing of most recent edition of the UCSC Manual
Quarterly Performance Measures / Report Card	Streamlined provider data collection, improved definitions of measures, added additional measures
QOCCs	Improved reporting, educated providers about QOCCs, improved documentation and executive review
PIP	Increased score from “partially met” to “met” status
NCQA	Completed NCQA accreditation process and achieved three year accreditation.

## Key Initiatives for FY14

Project	Initiative
Follow-up after Hospital Discharge	Closely monitor attendance to follow up appointments across the network and require providers to conduct additional outreach if appointments not attended
Quarterly PCP Performance Measure	Develop more efficient methods for tracking member PCP linkage and measure PCP linkage quarterly
Annual Performance Measures	Analyze current data in new ways to better target interventions to reduce ED and inpatient use
BEST Program	Implement BEST 4 <sup>th</sup> edition and track outcomes
Cultural Competency Committee	Transform current committee to better assess and meet the cultural, ethnic, racial, and linguistic needs of members
Delegation of UM Authorizations	Begin process of transiting the remaining delegated authorizations from the CMHCs back to BHI without interrupting client care
Integrated Care	Develop additional mechanisms for measuring and monitoring coordination and integration of care
Substance Use Disorder (SUD) Services	Develop metrics and improvement activities to monitor SUD services

## Barrier Analysis and Planned Interventions

The primary barriers to a more effective QI program for BHI are all data related: data quality, data timeliness, and data consistency. The table below shows the specific data barriers encountered and the interventions planned to address these barriers.

<b>Barrier</b>	<b>Planned Intervention(s)</b>
Not maximizing the reports from Administrative Service Organization	Increase collaboration with Colorado Access to improve current reports and request additional reports to better meet BHI's data needs
Inconsistency of data submitted by providers	1. Develop scope document for Report Card to improve interpretation and consistency of measures 2. Develop audit procedure to improve quality of provider data collection (similar to BHI's ISCAT requirements)
Collecting complete data (and waiting for all providers to submit claims) often hinders timely interventions (e.g. recidivism data)	Continue ongoing assessment, prioritize on individual project basis

## NCQA Accreditation

In September 2012, BHI formally began the process of National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization (MBHO) accreditation. The 2013 standards required compliance in several categories: Quality Improvement, Utilization Management, Credentialing, Member Rights and Responsibilities, and Preventive Health. The NCQA accreditation process was project managed by the Quality Improvement team and entailed several policy changes and new policy implementation, the formalizing of previously informal procedures, and the re-structuring of several reports.

During the site visit of the accreditation process, the reviewers complimented the organization of BHI's submission and various reports and procedures. Several other programmatic strengths were also highlighted, including:

- BHI's innovative quality improvement and preventive health programs
- The knowledgeable, committed staff
- A strong focus on quality
- Well documented and compliant denial, appeal, and credentialing files

BHI is pleased to report that effective September 9, 2013, BHI received a full, 3-year accreditation.

*Goal for FY14*

Begin planning for re-accreditation process in FY16



## Population Characteristics and Penetration Rates

### Aid Categories and Average Member Months

The BHI member population varies slightly from month to month. During FY13, BHI was responsible for an average of 169,406 members. Table 1 shows the breakdown of the BHI member population by aid category.

**Table 1: BHI population characteristics**

Aid Category Description	12 Month Average	Percentage of Average Member Population
<b>Categorically Eligible Low-Income Adults (AFDC-A):</b> includes low income adults who receive Medicaid, families who receive Temporary Aid to Needy Families, and adults receiving Transitional Medicaid (adults in families who have received Medicaid in three of the past six months and become ineligible due to an increase in earned income)	32,290	19.1%
<b>Categorically Eligible Low-Income Children (AFDC-C):</b> includes children of low-income families and children on Transitional Medicaid.	79,588	47.0%
<b>Disabled Individuals to 59 (AND-AB):</b> these individuals are blind, have a physical or mental impairment that keeps them from performing substantial work, or are children who have a marked and severe functional limitation	12,034	7.1%
<b>Baby Care-Adults, Breast, and Cervical Cancer Program (BC-W, BCCP):</b> includes women with incomes up to 133% of the federal poverty level. Coverage includes prenatal care and delivery services, plus 60 days of postpartum care. Also covers women who were screened using national breast and cervical cancer early detection and prevention guidelines, and found to have breast or cervical cancer. These women are between the ages of 40 and 64, uninsured, and otherwise not eligible for Medicaid.	1,646	1.0%
<b>Baby Care Children (BC-C):</b> Children who are born to women enrolled in the Baby and Kid Care program (described above)	15,466	0.9%
<b>Foster Care (Foster):</b> Title IV-E provides federal reimbursement to states for the room and board costs of children placed in foster homes and other out-of-home placements. Eligibility is determined on family circumstances at the time when the child was removed from the home.	4,160	2.5%
<b>Adults 65 and Older (OAP-A):</b> Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. Supplemental An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources.	7,874	4.6%
<b>Disabled Adults 60 to 64, Working Adults with Disabilities (OAP-B, WAWD):</b> Colorado automatically provides Medicaid coverage to individuals who receive Supplemental Security Income. An individual must have income below the federal monthly maximum Supplemental Security Income limit and limited resources. Disabled adults aged 60 to 64 who are eligible for Supplemental Security Income are included in this category.	1,547	0.9%
<b>Non-categorical Refugee Assistance (NCRA):</b> mandatory full coverage for refugees for the first seven years after entry into the United States regardless of whether the individual is an optional or mandatory immigrant	189	0.1%
<b>Adults without Dependent Children (AWDC):</b> adults between the ages of 19-64, who earn approximately \$95 or less a month for a single adult (\$129 for a married couple).	1,444	0.9%
<b>Total</b>	169,406	100%

## Penetration Rates

### *Summary of project*

Penetration rates refer to the percent of members with at least one behavioral health contact during the fiscal year. Throughout this document are interventions designed to increase performance on several different aspects of member care. The calculation of penetration rates (broken down by age, race, eligibility type, and overall) helps BHI to better target interventions to improve member's access to timely, and appropriate services that meet their needs.

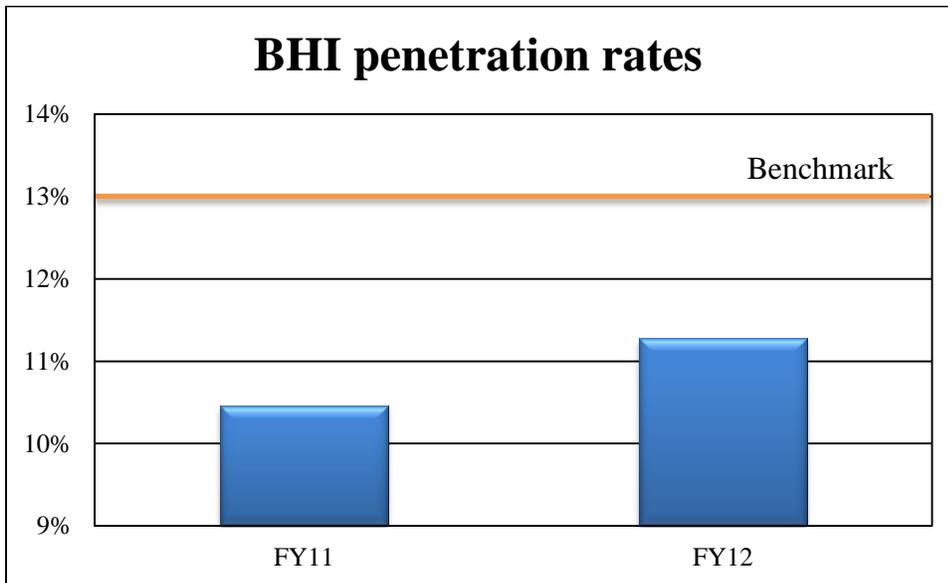
### *Goals from FY13*

- Improve penetration rates for adults and children by age category, aid category, ethnic group, and service category
- Outreach to BHI members, and conduct gap analysis to identify gaps in access to services and take necessary action

### *Results and analysis*

BHI increased overall penetration rates by 7.84% (10.46% to 11.28%) in FY13, as shown in Figure 1.

**Figure 1: BHI penetration rates**



### *Barrier analysis and planned interventions*

BHI reviewed the Uniform Service Coding Standards Manual along with the Performance Measures Scope Document and determined that two prevention and early intervention codes (H0023 and H0025) have historically been omitted from the calculation of penetration rates. The FY13 penetration rates will reflect the inclusion of these codes, likely resulting in an increase in our penetration rates.

With three Community Mental Health Centers (CMHCs) in the BHI catchment area (each covering three different yet overlapping geographic areas), BHI has historically found it difficult to assist the CMHCs in increasing outreach and member penetration from a geographic perspective. During FY13, BHI began a Geo-Coding project that maps out information such as:

- CMHC and CPN provider locations
- Addresses of members currently receiving services from a CMHC
- Addresses of members currently receiving services from CPN providers
- Addresses of members not currently receiving services

BHI will be able to use this information to better conduct assessments on the BHI network adequacy and connect members with providers that meet their geographical needs, thereby also increasing the BHI penetration rates.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Penetration Rates	Increase overall penetration rate by 2% from 11.28%.	Continue to assess penetration rates by age, race, and eligibility type to better target interventions	6/30/14
		Use Geo-Coding project to better target interventions	

## Network Adequacy and Availability

### **Ensuring Availability**

#### *Summary of project*

BHI continuously builds its provider network to meet the needs of members in Adams, Arapahoe and Douglas counties, and throughout Colorado. BHI members can receive services through three different service delivery systems:

- Prescribers: BHI defines a prescriber as one of the following:
  - Psychiatrist (either a Doctor of Medicine or a Doctor of Osteopathy) who is licensed by the Colorado Board of Medical Examiners
  - Physician's Assistant who is licensed by the Colorado Board of Medical Examiners
  - Advanced Practice Nurse with Prescriptive Authority (RxN) who is licensed who has been granted prescriptive authority by the Colorado Board of Nursing
- Practitioners: BHI and NCQA define a practitioner as any professional who provides behavioral health care services. This includes licensed practitioners in private practice and practitioners in the community mental health centers (CMHCs). It is noteworthy that the CMHCs also have many non-licensed mental health clinicians providing certain services. For the purposes of this report, "practitioners" includes only licensed clinicians.
- Providers/Facilities: BHI and NCQA define a provider as an organization that provides services to members, including hospitals, residential facilities, or group practices.

The US Department of Health and Human Services designates a psychiatric health professional shortage area (HPSA) when the prescriber to member ratio reaches 1:20,000 and the licensed mental health professional (MHP) ratio reaches 1:6,000. In December 2012, the BHI Leadership team set a standard for the provider-to-member ratio in the BHI catchment area. Because BHI strives to build a robust network, The BHI standard was set at 25% of the HPSA benchmark – for prescribers, a ratio of one prescriber per 5,000 members and for practitioners, a ratio of one practitioner per 1,500 members. As there is no state or national standard for facility ratios, BHI adapted the CMS guidelines for Medicare Advantage and state penetration rates to develop our own network standard. For providers/facilities, BHI's standard is set as one facility per 12,000 members.

#### *Goal from FY13*

Continue to conduct quarterly measurement, monitoring, and report to HCPF

- Through Delegation Oversight / Report Card follow-up process, oversee remedial action plans of providers

*Results and analysis*

The FY13 network performance and BHI standards are listed in Table 2 below, demonstrating BHI compliance with the standards for availability of services.

**Table 2: Provider availability in BHI catchment area**

	Total Number	Average members in FY13	Average Members in Catchment Area	Ratio	BHI Standard
Prescribers	77	169,406	153,302	1:1,991	1:5,000
Practitioners	659	169,406	153,302	1:233	1:1,500
Providers/Facilities	35	169,406	153,302	1:4,380	1:12,000

BHI monitors the number of prescribers, practitioners, and providers/facilities in each county of our catchment area to assure that our provider network is not only adequate but also robust to meet the needs of our members. BHI uses the same ratio standards as outlined above to assess the availability in each county of the catchment area. Table 3 reflects the different types of service delivery systems in the different counties of the catchment area and demonstrates BHI compliance with the standards of availability of services.

**Table 3: Provider availability in BHI catchment area by county**

Prescribers	Total Number	Average Members in Catchment area	Ratio	BHI Standard
Adams County	20	75,906	1:3,795	1:5,000
Arapahoe County	45	66,954	1:1,488	1:5,000
Douglas County	6	10,443	1:1,740	1:5,000

Practitioners	Total Number	Average Members in Catchment area	Ratio	BHI Standard
Adams County	172	75,906	1:441	1:1,500
Arapahoe County	270	66,954	1:248	1:1,500
Douglas County	35	10,443	1:298	1:1,500

Providers/Facilities	Total Number	Average Members in Catchment area	Ratio	BHI Standard
Adams County	13	75,906	1:5,839	1:12,000
Arapahoe County	21	66,954	1:3,188	1:12,000
Douglas County	1	10,443	1:10,443	1:12,000

In the process of evaluating the adequacy of BHI’s current provider network, we have concluded that the geographic distribution, cultural specialties, availability of bi-lingual clinicians in multiple languages, and array of provider that provide services across all contractually required State Plan and Alternative/B-3 services, is more than sufficient to meet the needs of BHI’s Medicaid membership.

*Barrier analysis and interventions*

Due to the diverse geographical locations of BHI members, BHI contracts with multiple providers and other community mental health centers outside of our catchment area to provide easier access to quality mental health services. BHI frequently examines adequacy of the provider network and how it relates to the changing Medicaid population.

BHI also develops Single Case Agreements (SCAs) with other facilities and providers as needed to service the needs of BHI members. BHI continues to increase capacity within its provider network and continuously encourages providers to become fully contracted and credentialed with BHI. The SCA providers make up 10% of the BHI Contracted Provider Network. At present, BHI has 102 SCAs.

Provider recruitment efforts are geared toward filling any provider gaps based on the distribution and demographics of Medicaid members. BHI also works collaboratively with the Director of Member and Family Affairs to identify any increasing trends or patterns identified through client assistance calls and grievances. If a member calls because they are having problems locating a provider in their area, BHI gives hands-on assistance to finding the member an appropriately qualified provider within reasonable traveling distance and/or helps them with transportation arrangements.

*Goal(s) for FY14:*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Network Adequacy – Ensuring Availability	Meet the geographical needs of members by assuring provider availability	Continue to assess provider network availability against BHI standards and respond to the needs of the ever-growing Medicaid population.	6/30/14

## Cultural Needs and Preferences

### *Summary of project*

Behavioral Healthcare, Inc. (BHI) believes that our mental health system must continuously evolve to reduce mental health disparities. Our primary goal is to meet the needs and expectations of the all members and families we serve with a robust network of culturally competent providers. Our providers excel at embracing divergent norms, beliefs, expectations, and resources and how these factors are related to cultural background and identity. BHI has recognized that quality care for all diverse communities depends on inclusion and accessibility of services. Staff members at BHI are trained to be conscious of and sensitive to, the cultural differences of our members.

BHI conducts ongoing assessment of demographic profiles of members who utilize services through monthly clinical reports and the assessment of census and eligibility data. Utilization rates by diverse member categories are calculated annually. BHI uses these assessments and other surveillance data to determine where and how to allocate cultural and linguistic resources to best serve the variety of individuals and communities we serve.

### *Goal from FY13*

No goal from FY13. However, through NCQA process, BHI has placed priority on assessing the cultural and linguistic needs of our members and adjusting the provider network (if necessary) to meet those needs.

### *Results and analysis*

Table 4 shows the demographics of the population in BHI’s catchment area – Adams County, Arapahoe County, Douglas County, and the city of Aurora.

**Table 4: Population demographics in BHI’s catchment areas**

	City of Aurora	Adams County	Douglas County	Arapahoe County
Persons under 5 years, percent, 2010	8.4%	8.3%	7.1%	6.9%
Persons under 18 years, percent, 2010	27.3%	28.4%	29.8%	25.3%
Persons 65 years and over, percent, 2010	8.9%	8.5%	7.8%	10.4%
Female persons, percent, 2010	50.8%	49.6%	50.5%	50.9%
White persons, percent 2012	61.1%	87.6%	91.8%	79.4%
Black persons, percent, 2010	15.7%	3.5%	1.4%	10.5%
American Indian and Alaska Native persons, percent, 2010	1.0%	2.1%	0.5%	1.1%
Asian persons, percent, 2010	4.9%	3.8%	3.9%	5.2%
Native Hawaiian and Other Pacific Islander, percent, 2010	0.3%	0.2%	0.1%	0.2%
Persons reporting two or more races, percent, 2010	5.2%	2.8%	2.3%	3.5%
Persons of Hispanic or Latino origin, percent, 2010	28.7%	38.2%	7.8%	18.7%
White persons not Hispanic, percent, 2010	47.3%	53.0%	84.8%	63.2%
Foreign born persons, percent, 2007-2011	20.4%	15.0%	6.0%	14.9%
Language other than English spoken at home, percent, 2007-2011	30.9%	27.6%	9.0%	21.9%
Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, County Business Patterns, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report, Census of Governments.				

BHI believes that linguistically appropriate services are crucial to service delivery. According to US census data from above (Table 4), an average of 22.4% of homes in the BHI catchment area speaks a language other than English. All members who access the network will be evaluated at intake to assess linguistic needs. If a member is in need of interpretation services, BHI will contact one of the resources available through a CMHC or the CPN (see Table 5 below). In cases where the language needed is not available within the network, BHI will access telephonic interpretation through Cyacom language services. A family member of the member will not be used to provide interpretation unless requested by the member.

**Table 5: Providers offering services in languages other than English**

	Arapahoe Douglas Mental Health Network	Aurora Mental Health Center	Community Reach Center	Contracted Provider Network	Total
Arabic	0	2	0	0	2
American Sign Language	2	2	0	5	9
Amharic	0	1	0	0	1
Cantonese	0	1	0	0	1
Chinese	2	1	0	0	3
Dutch	0	0	1	0	1
Farsi	0	2	0	0	2
French	3	2	0	4	9
Fuzhounese	0	1	0	0	1
German	4	3	0	0	7
Hindi	0	3	0	0	3
Igbo	0	1	0	0	1
Indonesian	0	1	0	0	1
Italian	3	3	0	0	6
Japanese	1	3	0	0	4
Khmer	0	1	0	0	1
Korean	0	3	0	0	3
Lao	0	1	0	0	1
Mandarin	0	3	0	0	3
Navajo	0	2	0	0	2
Nepali	0	4	1	0	5
Nigerian	0	1	0	0	1
Norwegian	0	1	0	0	1
Oromo	0	1	0	0	1
Pashto	0	1	0	0	1
Portugese	0	1	0	0	1
Serbo-Croa	0	1	0	0	1
Sinhala	0	1	0	0	1
Russian	5	0	0	1	6
Spanish	18	76	20	19	133
Swahili	0	1	0	0	1
Taiwanese	0	2	0	0	2
Tgrina	0	1	0	0	1
Urdu	0	1	0	0	1
Vietnamese	0	1	0	0	1
Yoruba	0	1	0	0	1

Although Colorado state and county census data shows a higher Caucasian population than Hispanic or Latino populations, BHI’s eligibility data shows a higher percentage of Hispanic population in the Medicaid population. In the last few years, BHI has increased efforts to better serve the Hispanic population by credentialing bilingual Spanish-speaking providers, outreach into the Hispanic community, hiring a bi-lingual receptionist, and training a staff member in professional Spanish translation.

BHI strives to meet our member’s linguistic and cultural needs by printing the Member and Family Handbook in both English and Spanish. The handbook is also available upon request in large print and in audio (English and Spanish) versions. Educational brochures and informational brochures are also available in other languages (including Braille) upon request. Informational flyers (such as the grievance procedure and member rights and responsibilities) are posted in each CMHC in both English and Spanish.

Since 2005, BHI has only received one compliant from a member regarding accessing providers that meet his/her linguistic needs (a Spanish speaking provider). BHI staff was able to link the member to a Spanish-speaking provider in one of the CMHCs. The member was satisfied with the resolution and the complaint was resolved within 14 days.

While BHI believes that our provider network adequately meets the needs of our member population, it is understood that our population is ever growing and ever changing. BHI is committed to continued assessment of the provider network and increasing the level of cultural competence and proficiency of our provider network.

*Barrier analysis and planned interventions*

BHI recognizes that while the linguistic assessment of the provider network is very strong, there has been difficulty assessing if the cultural needs of the provider network are consistent with the cultural needs of our members. BHI has planned the following interventions:

- The new BHI website will include a searchable provider database that will allow members to not only search for providers who meet their geographic needs, but search for providers that meet their cultural or linguistic needs as well.
- The Quality Improvement department will work with the Director of provider relations to gather more cultural and ethnic information from the network of BHI providers.
- The Quality Improvement department will include cultural, ethnic, and linguistic assessment items from the various member satisfaction surveys into the provider cultural assessment.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Develop a mechanism to identify cultural makeup of provider network to assess whether they meet members’ language needs and cultural preferences.	1/1/14
		Take action if network does not meet members’ language needs and cultural preferences.	

## Access to Services

### Access to Care

#### *Summary of project*

Access to care refers to the ease in which a member can obtain behavioral health services. Providing access to quality behavioral health services for members and families is central to the mission of BHI and its providers. Providers can be both facilities and individual practitioners. CMHCs are required to submit an access to care report quarterly. The CPN (including individual providers and facilities) is assessed through secret shopper calls. All providers are assessed through the member grievance process. Finally, BHI conducts an annual survey to a sample of members to assess specific access to care standards.

The four access to care indicators required by the Colorado Department of Health Care Policy and Financing (HCPF) include: Initial requests for routine services, urgent service requests, emergency face-to-face requests, and emergency phone calls.

- Initial requests for routine services include the non-urgent and non-emergent requests for services. The performance standard for this indicator is offering an appointment within seven business days.
- Urgent service requests include those situations in which acute mental health symptoms are present, have potential for an emergency health condition, or any other condition that would place the health or safety of a member or other individual in jeopardy in the absence of treatment. Urgent services require offering an appointment with 24 hours of the urgent request.
- Emergency face-to-face requests occur when a member presents with a condition manifesting itself with acute symptoms that require immediate medical attention/mental health services. Emergency Services (ES) shall be available in-person within one hour of contact (in urban and suburban areas).
- Emergency phone calls consist of after-hours calls, emergent and non-emergent to each center, and to BHI as reported by Protocol and BHR Worldwide. BHI does not have a centralized triage and referral center.

#### *Goals from FY13*

- Conduct secret shopper calls to assess quality and access to services, and identify need for training
- Continue to conduct quarterly measurement, monitoring, and report to HCPF. Measure Access to Routine, Urgent and Emergency Services

#### *Results and Analysis – CMHC Access to Care*

BHI's CMHCs are contractually required to report on access to care standards once a quarter. BHI's CMHCs have seen 12,817 unique members since July 1, 2013 (the start of Fiscal Year 2013), and have provided 66,130 services. The CMHCs continue to see the majority of BHI members.

To monitor performance and meet contractual requirements, each CMHC pulls access to care data from their Electronic Medical Record (EMR) and submits quarterly reports of the four access to care indicators to BHI (as seen below). BHI reviews and aggregates these reports and submits them to HCPF. HCPF has established performance standards for each indicator, typically at least 95%. Failure to meet the 95% performance standard requires a formal Corrective Action Plan (CAP).

While BHI has consistently met access to care performance standards in recent years, instances of non-compliance are of concern to HCPF, BHI, and CMHCs. The quarterly reports submitted to HCPF include a narrative explanation of patterns of non-compliance. Fiscal year to date reports required no narrative due to continued compliance. Other serious concerns may result in a formal CAP. In addition, BHI routinely reviews compliance concerns with CMHCs in the Program Evaluation and Outcomes Committee (PEO) to identify opportunities for improvement.

Table 6 below shows the past year of access to care standards for the CMHCs. Providing members with initial appointments within seven days has previously been difficult to meet due to the increasing amount of no-shows and staffing shortages. Since the CMHCs have implemented same-day access for BHI Medicaid members, the number of initial appointments outside the seven-day requirement has decreased. Same-day access allows for quicker and timelier appointments for BHI members.

The CMHCs have also implemented Emergency Services (ES) teams that work together to decrease the wait time for urgent and emergent services. Each CMHC has their own ES team located at specific center locations that can evaluate members for an urgent need within 24 hours. The CMHC ES teams also evaluate emergent needs of members at local emergency departments and hospitals.

As seen in Table 6, some routine services have taken place outside the seven-day requirement. These instances appear to be outliers at this time. There has been an ongoing issue with lack of appropriate documentation to prove that the appointment took place within the seven-day window. To correct this issue, BHI has required the particular CMHC where these appointments occurred to complete a corrective action plan.

**Table 6: CMHC access to care results for FY13**

Initial Requests for Routine Services				
	Q1	Q2	Q3	Q4
Offered within 7 days	1,989	1,973	2,152	2,027
Offered between 8-14 days	0	6	7	0
Offered in 15 day or more days	0	0	0	0
Percent Compliance	100.0%	99.7%	99.7%	100.0%
Percent Non-Compliance	0.0%	0.3%	0.3%	100.0%

Request for Urgent Services				
	Q1	Q2	Q3	Q4
Offered within 24 hours	177	62	53	74
Offered in greater than 24 hours	0	0	0	0
Percent Compliance	100.0%	100.0%	100.0%	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%

Emergency Face to Face				
	Q1	Q2	Q3	Q4
Offered within 1 hour	559	650	536	548
Greater than 1 hour but less than 2 hours	0	0	0	0
Greater than 2 hours	0	0	0	0
Percent Compliance	100.0%	100.0%	100.0%	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%

Emergency Phone Calls				
	Q1	Q2	Q3	Q4
Offered within 1 hour	3,596	3,170	3,514	3,782
Greater than 1 hour but less than 2 hours	0	0	0	0
Greater than 2 hours	0	0	0	0
Percent Compliance	100.0%	100.0	100.0	100.0%
Percent Non-Compliance	0.0%	0.0%	0.0%	0.0%

#### *Results and Analysis – CPN Access to Care*

BHI also conducts annual Secret Shopper calls with the CPN providers to monitor provider knowledge related to access to care standards, available services for members, availability of urgent appointments, responses to questions related to family and guardian issues, cultural competency, and responsiveness. The results guide BHI in developing specific training to ensure that providers are providing information based on BHI’s contract with HCPF and related Medicaid regulations.

The Secret Shopper calls entail a BHI staff member calling various providers pretending to be members and requesting information and/or access to services. Questions for the Secret Shopper calls were formulated based on feedback from two member focus groups. Using this information, BHI developed the Secret Shopper Checklist and sample scenarios. BHI’s CPNs were telephoned and scored using the following scale: unacceptable (1), acceptable (2), or good (3) rating. Scores were totaled for each provider.

Nine CPN providers were called. Of these nine providers, two were excluded for the following reasons: one provider was not currently accepting BHI Medicaid clients, and one provider could not be reached despite several attempts at contact. Since this was a Secret Shopper assessment, no voicemails or messages were left for providers. Nine points were possible for each provider related to access to care.

**Table 7: Secret shopper results**

Provider	Score	Percent Compliant
A	7	77%
B	5	56%
C	7	77%
D (Spanish)	5	56%
E (Spanish)	8	88%
F	8	88%
G	8	88%

The average point value for all the CPNs assessed was seven, meaning a compliance average of 77%. BHI has set a goal of to have at least 95% average compliance on the secret shopper calls. BHI plans to redesign the secret shopper calls to assess more accurately our CPN access to care.

The CPNs were called during the holiday season. BHI understands that this assessment is a snapshot in time and not indicative of insufficient ability to meet access to care standards. Two CPN providers were unable to provide timely access to a face-to-face appointment due to staff being away for the holidays. No alternative option was recommended. The CPNs should be providing clear direction to Medicaid members when a face-to-face appointment cannot take place (e.g., giving their clients the Medicaid Nurse Advice Line number, information about the drop-in centers and/or peer specialists, or how to make an appropriate referral to the CMHCs).

BHI would like to determine if these particular set of results were “holiday dependent” or if the results are indicative of the entire year. Therefore, BHI plans to reassess CPN access to care once a quarter.

*Results and Analysis – Member Satisfaction with Access to Care*

Satisfaction surveys provide BHI with knowledge on member perceptions of well-being, independence, and functional status as well as perceptions on the scope of services offered, accessibility to obtain services when needed, availability of appropriate practitioners and services, and acceptability or “fit” of the practitioner, program, and services in meeting the members’ unique needs and preferences. This feedback helps to modify the service system for actual utilization patterns and enables member choice. If a pattern is detected or there is a statistically significant level of concern, BHI requires and/or develops a corrective action plan.

For 2013, BHI conducted an additional survey of 15 questions to assess Utilization Management services and Access to Care as well as to assess more thoroughly acceptability or “fit” of the practitioner, program, and services in meeting the members’ unique needs and preferences. The Access to Care questions specified “In the past 12 months:”

- If you had a mental health emergency and you contacted your mental health provider, were you contacted by someone within 1 hour or told to go to the emergency room?

- If you had an urgent need to speak with someone about your mental health, called someone, were you contacted within 24 hours of your initial call?
- If you needed to schedule a routine office visit, were you scheduled and seen within 7 days of your request? The answer choices available were: yes, no, and N/A.

The total population size used for determining the needed number of completed surveys was 15,444 members. This was the total number of members who received services from the start of FY13 (July 1, 2012) through January 24, 2013 when the sample was obtained. Using the sample size calculator, it was determined that 390 members was a sufficient overall sample size. The sample size calculator prepares a random sample where  $n = N/(1+(N*0.0025))$  where sample error & confidence level = 0.05 & 95% from the study population, with a 5% oversample.

Based on previous year return rates, BHI sent out three times the amount of surveys completed last year to the three CMHCs, two drop-in centers, and mailed surveys to a random sample of members using the CPN. The surveys were administered from February 13, 2013 through April 12, 2013.

BHI distributed 2,515 surveys to the CMHCs, Drop-in centers, and CPN members. Eight hundred and fifty-six (856) Access to Care surveys were completed and analyzed (35% response rate). Based on the number of completed surveys, BHI met its sample size and determined all surveys that were completed would be used in the results and analysis.

BHI analyzed results by using pivot tables in Microsoft Excel. The applicable score is the number of surveys that were completed for a particular question minus the number of N/A answers for that question. The “yes” answer number reflects the number of members who reported receiving appropriate care within the specified period of time for that question. The percent that answered “yes” is the total “yes” answers divided by the applicable score. The results are listed in Table 8 below.

**Table 8: Member satisfaction with access to care**

	Applicable Score	"Yes" Answer	Percent that answered "Yes"
Emergency	304	215	70.72%
Urgent	387	320	82.69%
Routine	637	525	82.42%

Since this is the first time BHI has assessed member satisfaction with member’s ability to receive timely service appointments, BHI did not set a specific goal for this measure. BHI believes that a five-percentage point increase from this year’s surveys to next year’s would be a marked improvement for each category.

Member perception of emergent and urgent care could vary greatly from BHI’s definition, so it would be important for BHI to educate members on not only definitions, but also access to care standards. BHI has considered revising the questions for next year’s survey to give the specific definition of each appointment type within the survey.

*Results and Analysis – Overall*

Since the CMHCs see the majority of members and compliance remains above 99%, BHI believes the CMHCs are providing timely accessibility of services. BHI has identified opportunities for improvement in other areas of assessment and will have the appropriate interventions completed during Fiscal Year 2014. This timeframe will allow BHI enough time to complete each of the interventions listed, and measure the effectiveness of those interventions in next year’s report.

*Barrier analysis and planned interventions*

CPN Access to Care: In the past, BHI has focused most quality improvement initiatives for this measure on the CMHCs. Through the secret shopper project, it has become clear that many of our CPN providers are unaware of most access to care standards, despite being listed in their provider contracts and the provider manual. To address this deficiency, BHI has planned the following interventions:

1. Educate CPN providers about how to properly refer clients and manage staff shortages during the holiday season
2. Educate with providers through the quarterly provider bulletin about access to care standards
3. Conduct the “secret shopper” calls on a quarterly basis
4. Complete an inter-rater reliability session with the individual staff members who are making the secret shopper calls to the CPN to help improve the accuracy of scoring

BHI has only begun measuring member satisfaction with access to care this year. It became evident with some of the member comments that accompanied their responses to the access to care questions on the survey that there was a great deal of confusion about the definitions of routine, urgent, and emergent care. Therefore, BHI plans to educate its members about access to care services and standards to help them have a better understanding of how BHI defines emergent, urgent, and routine appointments and will consider revising access questions for clarity purposes in next year’s survey. To address other concerns identified from the member satisfaction survey, BHI plans to:

1. Since mental health emergency access was the lowest score, BHI will concentrate on this access to care point for interventions. BHI will have each of its CMHC check individual clinician voicemails to make sure members are directed to the emergency room if they do not receive a response from the clinician within one hour.
2. BHI will communicate the same information with the provider network through the provider bulletin and follow-up to make sure this has been completed

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Access to routine, urgent, and emergency services	Provide access to covered services as indicated in the Medicaid standards for access to care	Increase provider education about access to care standards	1/1/14
		Increase frequency of secret shopper calls to CPN providers	
	Improve member satisfaction with Access to Care by 5%	Educate members about definitions of routine, urgent, and emergent appointments and the associated standards	

## Access to Medication Evaluations

### Summary of project

Medication evaluations are comprehensive assessments completed by psychiatric providers in order to assist in diagnosis development and begin any necessary medication regimens that complement the other therapeutic services the member may be receiving. It is crucial to offer members medication evaluations in a timely manner in order to facilitate effective treatment. Many members cannot fully benefit from other therapeutic services until their symptoms (particularly acute) are addressed.

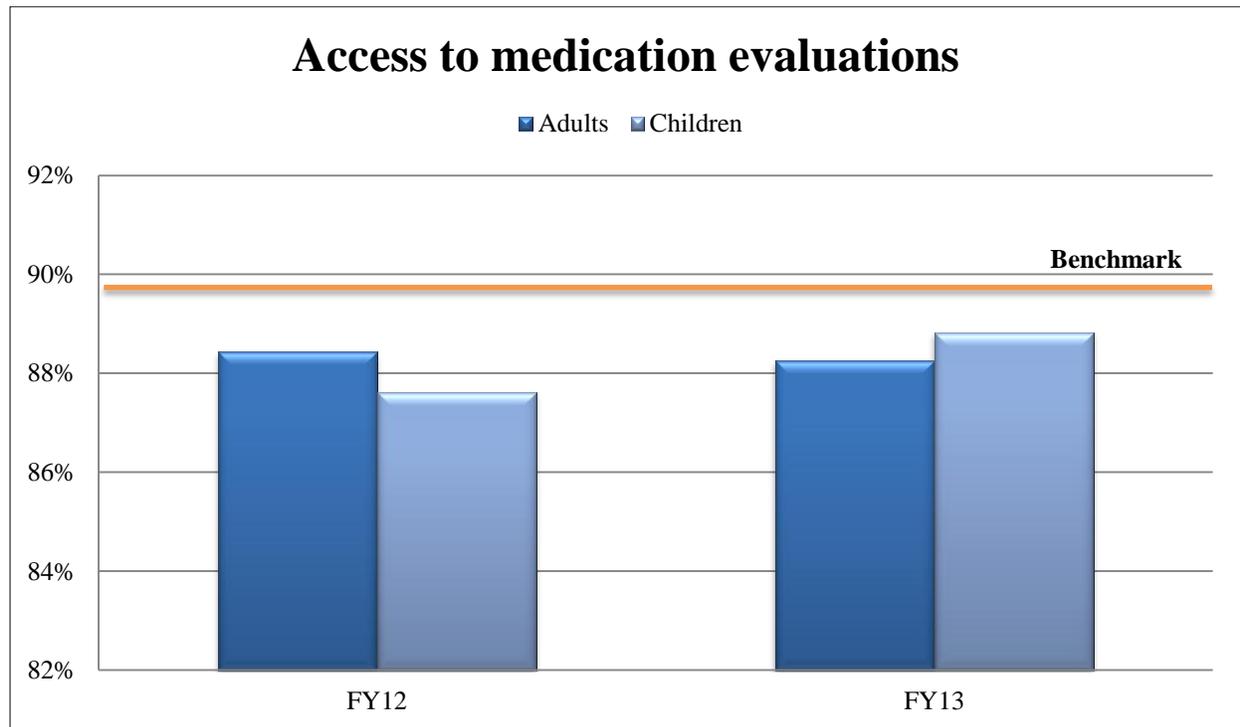
### Goal from FY13

- Ongoing measurement, evaluation and corrective action to improve access
- Work with CMHCs to improve this indicator (data collection, interventions, etc.)
- Ongoing re-measurement of access 30 days quarterly by CMHC and age group (adult/youth). A corrective action plan is required if CMHC falls below the 90% benchmark

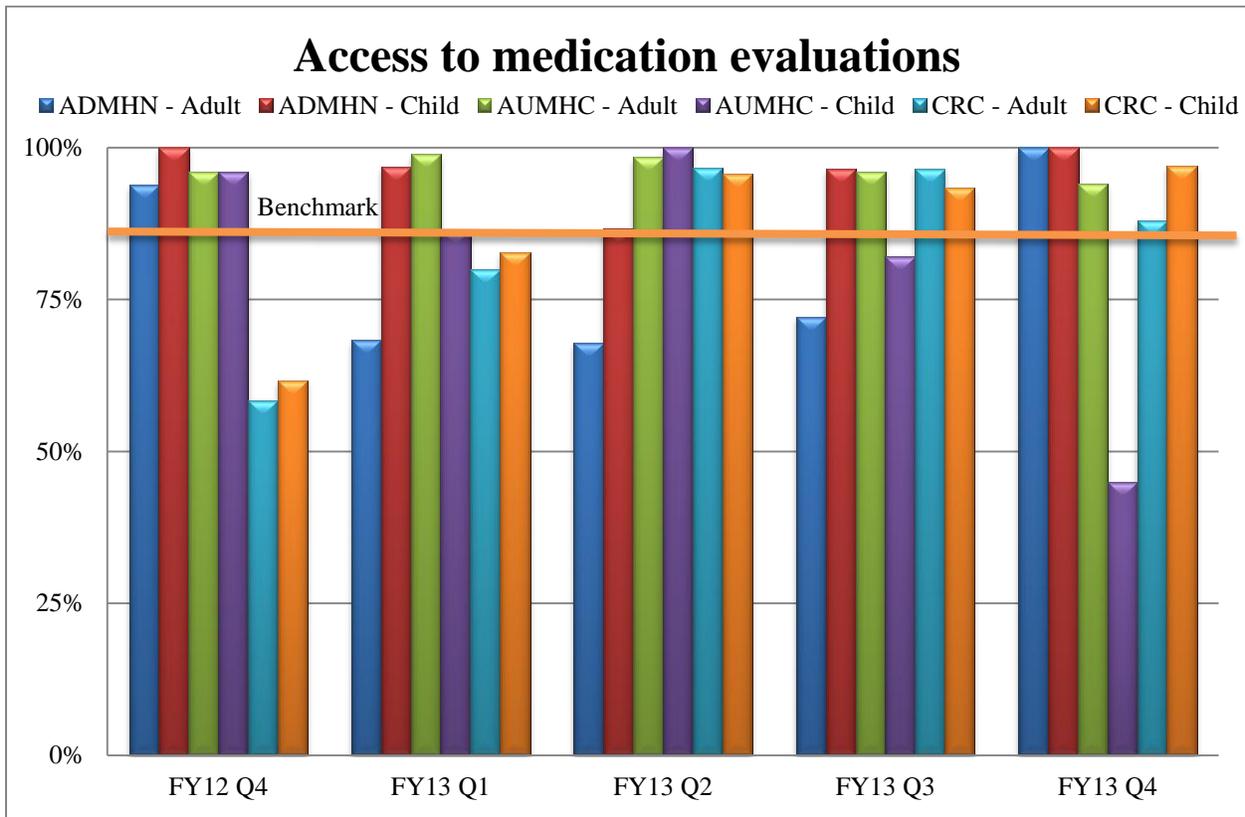
### Results and analysis

Figure 2 shows the percent of members offered a medication evaluation within 30 days of the request for a medication evaluation. BHI set a performance standard of 90% compliance on this measure based on a previous focused study. Any performance under the 90% standard requires a CAP from the CMHC. Figure 2 demonstrates overall BHI performance, while Figure 3 demonstrates performance by each CMHC over the past 5 quarters. Due to the timing requirements for the CAP, an improvement in performance would not be expected until two quarters after the current data.

**Figure 2: Overall performance on access to medication evaluations indicator**



**Figure 3: Performance on access to medication evaluations by CMHC and by quarter**



*Barrier analysis and planned interventions*

Each CMHC is coping with various barriers to improving their performance on this measure. Community Reach Center (CRC) identified a difficulty getting members psychiatric care in urgent or emergent situations due to the tight schedules and large caseloads of their prescribers. To help improve member access to care, CRC has implemented an “urgent psychiatric day clinic” for current, open members to be seen in urgent situations. The clinic is operated by one psychiatrist, one advance practice nurse, two registered nurses and is overseen by the Medical Director. The goal of this clinic is to make psychiatric care more accessible to members and to treat urgent or emergent situations as they occur. A long-term goal is to decrease the number of emergency department visits and hospitalizations.

In adult services, Arapahoe/Douglas Mental Health Network (ADMHN) identified that their prescribers were often spending a large portion of the appointment time taking vitals, reviewing systems, and checking on any lab work. To address this, all prescribers and their supporting RNs were moved to one medical office suite. The RN/LPN meets with the patient first to do vitals, a review of systems, check on lab work, then the prescriber completes his/her assessment, and the RN/LPN follows up with any case management needs and coordination of care. This allows the prescriber to see more members in each hour. ADMHN has also recently implemented tele-psychiatry into practice at one specific location. Members use this service for follow-up visits, which creates more open appointment opportunities for those seeking an initial medication evaluation.

Aurora Mental Health Center (AUMHC) has identified that their largest barrier to meeting compliance is likely due to staffing. During the interim, the QI Director is continuing to send medication evaluation reports to all Deputy Directors and the Medical Director on a monthly basis and they will remind their teams of the timelines and remind managers that they can schedule medication evaluations on different teams to meet the requirement as best they can until staffing can be adjusted.

*Goal(s) for FY14*

Continue to monitor access to medication evaluations and require corrective action for any provider who falls below the 90% benchmark.

Project Title	Goal(s)	Action(s)	Target Date
Access to medication evaluations	Provide access to medication evaluations within 30 days of client request for service	Assist providers in barrier analyses to identify opportunities to improve access to medication evaluations.	6/30/14

## Focal Point of Behavioral Health for SMI Population

### *Summary of project*

BHI monitors the BHO-HCPF Annual Performance Measure data to identify opportunities for improvement. One such indicator measures the percent of adult members with SMI (Diagnosis of Schizophrenia, Bipolar Disorder, or Schizoaffective Disorder) who have a focal point of behavioral health care identified (three or more behavioral health services or 2 or more prescriber services in a 12 month period). Note that FY12 performance measures are included in this report as the FY13 measures are not calculated until fall of 2013.

### *Goal from FY13*

Although no goal was identified in the Quality Improvement Work Plan from last year, BHI informally sets a goal to be at or above the average percentage across all BHOs.

### *Results*

In FY12, 92.77% of BHI members with SMI had a focal point of behavioral health. This was the second highest percentage of all the Colorado BHOs and above the statewide average of 89.88%. BHI considers this objective met.

### *Goal for FY14*

BHI aims to continue to perform at or above the statewide average for this performance indicator.

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Focal point of behavioral health services	Continue to perform at or above the statewide average for this performance indicator.	Continue to monitor clients' accessibility to services	6/30/14

## Compliance Monitoring

### External Quality Review Organization Audit (EQRO Audit)

#### *Summary of Project*

BHI underwent the ninth EQRO audit and site visit in FY13. HCPF focused review on four standards: Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Re-credentialing, and Quality Assessment and Performance Improvement. Compliance with federal regulations and contract requirements was evaluated through review of these four standards.

#### *Goals from FY13*

- Participate in annual, external independent reviews of the quality of services covered under the Medicaid contract
- Coordinate with HSAG (Health Services Advisory Group) to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols

#### *Results and analysis*

Table 9 below represents the score in each category for BHI.

**Table 9: FY13 EQRO audit results**

Standard	Number of Elements	Number of Applicable Elements	Number Met	Number Partially Met	Number Not Met	Score
Coordination and Continuity of Care	8	8	8	0	0	100%
Member Rights and Protections	5	5	5	0	0	100%
Credentialing and Re-credentialing	49	47	45	1	1	96%
Quality Assessment & Performance Improvement	16	16	14	1	1	94%
Totals	78	76	73	1	2	96%

BHI's strongest performances were in Coordination and Continuity of Care and Member Rights and Protections, both of which earned a compliance score of 100 percent. HSAG identified two required actions in Credentialing and Re-credentialing (96 percent compliant) and one required action in Quality Assessment and Performance Improvement (94 percent compliant). BHI demonstrated strong performance overall and a comprehensive understanding of the federal health care regulations, the Colorado Medicaid Managed Care Contract, and NCQA Standards and Guidelines and earned an overall compliance score of 96 percent. Therefore, BHI considers this objective met.

#### *Barrier analysis and planned interventions*

One of the more prominent areas of improvement suggested by HSAG was for the QI program to "close the loop" of information and projects. For example:

- BHI was often completing projects but not appropriately documenting the presentation of results to various stakeholders – whether HCPF, providers, or members.
- Implemented interventions were often not being documented appropriately and/or linked back to the initial project goals appropriately.

Therefore, BHI has created a series of processes to assure that each project “closes the loop.” This includes the implementation of several procedures, such as:

- Using a project management approach to each QI project, including completion percentages and outlined tasks, such as presenting results to stakeholders
- Restructuring the Annual Quality Report to reflect the more complete project management, including barrier analyses and interventions for each project

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
External Quality Review Organization (EQRO) audit	Continue to score at or above the previous year’s performance	Participate in annual, external independent reviews of the quality of services covered under the Medicaid contract Coordinate with HSAG (Health Services Advisory Group) to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols	6/30/14

## **Focused Study: Population-Based Patterns in the use of BHI Medicaid Managed Care Mental Health Services**

### *Summary of project*

The purpose of this focused study was to identify BHI member demographics and utilization patterns of mental health services including emergency department visits, inpatient hospitalization stays, and outpatient services received. This study identified individuals by Medicaid eligibility category, age, ethnicity, gender. This study hoped to present information on areas of improvement for mental health services and to identify areas where early prevention and intervention were needed. BHI examined the data analysis results and determined appropriate interventions and changes in practice for population based care.

BHI Members eligible for this study were identified through BHI Medicaid Eligibility files, enrolled for nine out of twelve months during the study period, FY12 (July 1, 2011 – June 30, 2012). BHI encounter files were used to identify members with at least one mental health service as well members who used ED, inpatient, and outpatient services in the study period. GraphPad was used to calculate the chi square value and determine if there was a significant difference between the demographic category that used an ED, inpatient, or outpatient service in FY12 and the total population of members who received any service during FY12 for the same demographic category.

### *Goals from FY13*

- To coordinate with HSAG to ensure that projects are designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services while showing confidence in the reported improvements
- Meet all submission requirements for new Focused Study

### *Results and Analysis*

The results were calculated using GraphPad's chi-square 2x2 contingency table. The results produced a chi square value and significance level for each category was determined. Each demographic category (from the FY12 services – ED, Inpatient, and Outpatient) was compared to the same demographic category for all individuals who received a service in FY12 and met eligibility criteria.

We found that there were fewer inpatient claims for children and more for adolescents than in the overall population; and more inpatient claims for Aid to Needy, Disabled, Blind eligibility than in the overall population. Similarly, there were fewer emergency department claims for children and more claims for adolescents and adults than in the overall population. There were fewer emergency department claims for AFDC-C (children) eligibility and more claims for AFDC-A (adult) eligibility, mirroring the age category findings. In addition, there were more emergency department claims for women and fewer for men than in the overall population.

Because the study was exploratory, the results are not presented in terms of identified goals and benchmarks. The study was successful because we identified which demographic groups are using ED, inpatient, and outpatient services for mental health care. The results demonstrate that BHI members utilize services at similar rates across service categories, with some differences among age groups, gender, and Medicaid eligibility.

*Barrier analysis and planned interventions*

The study’s purpose was to identify BHI member demographics and utilization patterns. Prior to the study, it was unknown if over- or under-utilization occurred at all in the populations of interest, and so the study was undertaken to identify utilization patterns that may indicate possible over- or under-utilization. While we found that some differences in utilization were present, all of the observed differences likely were due to factors unrelated to clinical practice, and thus not recommended for intervention. For example, adolescents and adults using more emergency department services appears to be closely related to the necessity for parental involvement in receiving services, rather than a lack of service availability that would indicate a need for intervention.

Similarly, the findings regarding gender utilization differences are likely associated with differing cultural gender expectations (i.e., men are less likely than women to seek mental health services in general) rather than service provision deficiencies that would call for an intervention. While it is possible that additional communication outreach may address some of the observed utilization differences, we concluded that the differences did not warrant outreach efforts, as they were unlikely to cause significant changes and would consume resources that may be used more effectively elsewhere. We believe that this was a meaningful and useful quality improvement study because we examined for possible service over- or under-utilization and *did not* find over- or under-utilization to the extent that intervention or outreach efforts were indicated. In addition, the study provided us with a base for continued investigation and comparison to ensure that service over- or under-utilization does not occur.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Performance Improvement Projects and Focused Studies	Develop research projects designed to improve the quality of client care	Participate in the HCPF statewide Performance Improvement Project (PIP) and meet all requirements.	6/30/14

## Delegation Oversight

### Summary of project

BHI conducts annual evaluations of each of its delegates and the various functions for which each delegate is responsible. These evaluations require the delegates to submit evidence of compliance for each delegated function, including policies, reports, trainings, etc.

### Goal from FY13

Evaluate and ensure compliance with delegated functions

- Conduct Oversight Audits
- Monitor corrective action plan implementation and completion as applicable

### Results

BHI conducted the delegation audits beginning in fall 2012. The results of the delegation audit of the three community mental health centers and Colorado Access are listed below. Each CMHC also completed a Corrective Action Plan to address any areas scoring less than full compliance, including policy and procedure revisions, training, and revision of member materials.

**Table 10: COA delegation oversight audit results**

Function	COA Score
<b>Administrative Duties</b>	
A. Establish and Maintain a system of data integrity processes	2
B. Maintain the integrity and security of all data	2
C. Maintain back up files of all BHI data	2
D. Establish and maintain and system of quality assurance	2
<b>I. Claims and Encounter Processing and Adjudication</b>	
1A. Processing all claims and encounter data	2
1B. Necessary system configuration /modifications	2
1C. Processing of all claims adjustments	2
1D. Preparation of encounter and claims data for submission to HCPF	2
1E. Preparation of any additional or modified reports	2
<b>II. Decision Support and Required Reporting</b>	
2A. Submission of monthly, quarterly and annual reports	2
2B. All reports shall be submitted to BHI for review and approval	2
2C. The list of reports is subject to revision	2
<b>III. Tactical Reports</b>	
3A. Preparation of various operational, financial, and quality reports	2
<b>IV. Network Development and Provider Relations</b>	
4A. Claims Support	2
4B. Credentialing and Provider Database Management Services	2
<b>V. Clinical/Care Management Services</b>	
5A. Three FTE Care Managers	2
<b>VI. Eligibility and Database Services</b>	
6A. Loading of eligibility data	2
6B. Preparation of mailing labels for new client mailing	2
6C. Preparation of mailing labels for annual member mailing	2
<b>Totals (38 points total)</b>	
Total Points Scored	38
Overall Percentage	100%

**Table 11: CMHC delegation audit results**

Function	ADMHN Score	AUMHC Score	CRC Score
<b>2A. Access for Services</b>			
2A2. Center hours of operation	0	1	1
2A3. Timely and accurate data submission to measure access	2	2	1
2A5. Opportunities for improvement	2	2	1
2A6. Post-hospital discharge follow up appointments	0	2	2
<b>2B. Utilization Management</b>			
2B1. Referral and triage decisions by licensed practitioners with 2 years post-master experience	2	2	2
2B2. Inpatient referral and triage decisions are overseen by board-certified psychiatrist	2	2	1
2B3. Licensed and experienced behavioral healthcare practitioners supervise all treatment review decisions	2	2	2
2B4. Licensed behavioral healthcare practitioners from appropriate specialty areas assist in making determinations	2	2	2
2B5. Timeliness of UM decision making	1	2	0
2B6. Written description of UM decision making process	2	2	2
2B7. Evidence of consistent application of UM criteria	0	0	0
2B8. Coordinates a member's transition when benefits end	2	2	2
2B9. A psychiatrist reviews any Action or Action Recommendation based on medical necessity	2	2	1
2B10. A notice of Action is sent to the member each time an action is conducted.	2	2	2
2B11. Assigns a mental health professional to provide care coordination for BHI members	2	2	1
<b>2C. Member Services</b>			
2C2. Posts information on Enrollee Rights and Grievance Procedures and information on Ombudsman program at all clinical sites.	0	2	0
2C3. Grievance and appeal policies and procedures	2	2	0
2C4. Grievance/Appeal training to all new staff	0	1	0
2C5. Annual Grievance/Appeal training for all staff	0	0	2
2C6. Policies and procedures for interpreter services	2	2	2
2C8. Advance directives	2	2	0
<b>2E. Compliance Monitoring and Program Integrity</b>			
2E1. DBH licensure	2	2	2
<b>2F. Provider Relations</b>			
2F1. Quarterly network adequacy reports	2	2	2
<b>Totals (46 possible points)</b>			
Total Points Scored	33	40	28
Overall Percentage	71.7%	87.0%	60.9%

*Barrier analysis and planned interventions*

BHI encountered several barriers during the delegation oversight audit process. Through the NCQA process, it came to our attention that the written delegation agreements with the CMHC were actually a combination of delegated functions (such as UM authorizations) and contractual requirements (such as access to care standards). While the contractual requirements and various standards still require a degree of oversight, that oversight process is different from that of a delegated function. Therefore, the contracted standards will be included in the CMHC provider contracts rather than in the written delegation agreements.

However, BHI is currently working with the community mental health centers to regain all authorization responsibilities; therefore, delegation agreements with the CMHCs will no longer be necessary.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Delegation Oversight	Re-design Utilization Management department in order to manage all service authorizations 24 hours per day, 7 days per week	Transition the remaining delegated authorizations from the CMHCs back to BHI without interrupting client care	1/1/14
		Train all relevant service providers on authorization changes	
	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as our Administrative Service Organization through Delegation Oversight Audits	6/30/14

## **Encounter Data Validation Audit (411 Audit)**

### *Summary of project*

Three service program categories were selected by the Department of Health Care Policy and Financing (HCPF) for review in this year's audit. The categories are outlined as follows:

- 137 encounters from prevention/early intervention services (Service Category "HT")
- 137 encounters from club house or drop-in center services (Service Category "HB")
- 137 encounters from school-based services (Service Category "TJ" or "HE" with POS 03)

BHI used the 411 sample to identify lists of encounters/claims by provider. This year, largely due to the format of this year's audit, all claims in BHI's 411 sample consisted of CMHCs. Once the 411 sample was developed, BHI communicated with the QI Directors for the CMHCs during meetings as well as via phone and email about the records being requested. CMHCs in the CPN were mailed a letter requesting the appropriate records.

Both ADMHN and CRC provided BHI with remote access to their Electronic Medical Records (EMRs). AUMHC and the Mental Health Center of Denver (MHCD) granted BHI on-site access to their EMR. The remaining provider (Southeast Mental Health Services) submitted their records via mail.

To create the audit tool, BHI modified the Excel spreadsheet containing the 411 sample to include columns for auditor comments next to each required field for the audit. BHI used numbers to code the results of each audit field, per Appendix II of the Annual BHO Encounter Data Quality Review Guidelines (1 = compliance, 0 = non-compliance). If a field was found to be non-compliant, the auditor indicated the reason for non-compliance in the adjoining comment box. The audit tool was tested and validated during the inter-rater reliability session with all auditors. The auditors were instructed to make sure that all assigned fields were completed for each encounter they audited before they closed the medical record. Each auditor found the tool both simple and efficient to use during the audit process.

Three auditors conducted the audit of the 411 sample. All three auditors had extensive experience in behavioral health, maintaining, and reviewing clinical records. The lead auditor has prior experience with the Encounter Data Validation audit. Prior to any records being reviewed, training was conducted by the lead auditor and covered the following topics:

- The Annual BHO Encounter Data Quality Review Guidelines
- Scoring criteria for the various audit fields
- Review of the Uniform Service Coding Standards Manual (including the transition from the 2009 manual to the 2012 manual); both the 2009 and 2012 versions of the USCS manual were used depending on the date of service
- Navigating each of the CMHC EMR systems and where to locate the necessary information

The three auditors included:

- Lindsay Cowee, LPC, CACII (Manager of Quality Improvement, lead auditor)
- Jessie Wood, LPC, (QI Project Manager)
- Megan Pope, LPC, CACIII (QI Project Manager)

BHI provided three-hour training to all auditors. Five records were used as practice records. Auditors were given specific instructions for each EMR, including where to locate the necessary information within the EMR. Both hands-on training and hardcopies of instructions for EMR access were provided. During the practice session, auditors rated the records and had an open discussion on any issues with abstraction. Following the practice session, an inter-rater reliability study was conducted on 10 records. The records were projected on a screen and all auditors abstracted data individually with no discussion. An inter-rater reliability analysis summarized the results and provided kappa scores for each of the auditors. The lead auditor, Lindsay Cowee was used as the standard for the validation process. The other two auditors scored 96.4% agreement (with kappa = 0.839) and 99.1% agreement (with kappa = 0.955) to the standard. These scores were considered “almost perfect agreement.”

BHI conducted most of the audits in a group format. Any problematic records were reviewed by more than one person. The teams arrived at audit results after discussion and reference to the Uniform Service Coding Standards (USCS) manual and the Diagnostic and Statistical Manual (DSM-IV). Several checks were conducted in the data analysis process that also acted as internal over read.

The audit tool was used to verify the accuracy and completeness of auditor abstraction. Pivot tables were created to analyze the results for the required fields and overall audit performance. QI auditors verified all required fields based on auditor comments. Any missing information was gathered from the medical records and consultation with clinicians and administrators. Data analysis was conducted using the complete and accurate file. Pivot tables were created to calculate scores for each required field.

*Goals from FY13*

- Review statistically valid sample of encounter claims submitted to the Department
- Review activities conducted in accordance with CMS mandatory activity protocols
- Ensure that providers accurately document the services provided and use accurate codes on the encounters they submit
- Based on results of the medical record audit described above, BHI will require Core Providers to submit a corrective action plan to address findings if performance falls below benchmarks.

*Results and analysis*

The tables below list the elements that were scored for each encounter and a breakdown of audit score by program service category.

**Table 12: Audit scores by program service category**

<b>Program Service Category Comparison</b>	
Overall - all categories	74%
Prevention/Early Intervention Services	77%
School-Based Services	88%
Drop-In Center Services	56%

**Table 13: Audit scores across all providers and program service categories**

Audit Element	# of Claims / Records Accurate	# of Claims / Records Audited	% Records Accurate	Assigned Weight	Weighted Score
Diagnosis Code	377	411	92%	5%	5%
Start Date	387	411	94%	5%	5%
End Date	387	411	94%	5%	5%
Procedure Code	317	411	77%	15%	12%
Place of Service	374	411	91%	10%	9%
Service Category	357	411	87%	10%	9%
Duration	243	411	59%	15%	9%
Units	218	411	53%	15%	8%
Population	379	411	92%	5%	5%
Mode	386	411	94%	5%	5%
Staff Credentials	166	411	40%	10%	4%
<b>Overall Compliance</b>	<b>3,591</b>	<b>4,521</b>	<b>79%</b>	<b>100%</b>	<b>74%</b>

Each year, HSAG pulls a random sample of the 411 claims to perform an over-read audit in order to check the accuracy of audit methodology of the behavioral health organizations. This provides BHI with inter-rater reliability scores between our internal audit team and the state’s external quality review organization. The below table reflects the combined scores for all BHOs on the over-read audit and the individual scores for BHI. BHI scored a 100% in the majority of categories. These scores reflect a commitment by BHI to provide thorough and comprehensive audits on a continuous basis. The quality improvement department strives to be consistent in their audits and the scores below reflect a very high inter-rater reliability between the BHI audit team and HSAG, an accomplishment that has been found to be very helpful to our individual providers during the audit feedback and corrective action process. Table 14 below shows BHI performance on the over-read audit results as compared to the statewide BHO average.

**Table 14: BHI 411 over-read audit results**

	All Claims		PEI		Drop In		School	
	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI	All BHOs	BHI
<b>Overall</b>	<b>77.3%</b>		<b>78.0%</b>		<b>82.0%</b>		<b>72.0%</b>	
Procedure Code	84.0%	93.3%	82.0%	100%	84.0%	80.0%	86.0%	100%
Service Category	94.0%	100%	100%	100%	100%	100%	82.0%	100%
Diagnosis	97.3%	100%	94.0%	100%	100%	100%	98.0%	100%
POS	98.7%	100%	98.0%	100%	100%	100%	98.0%	100%
Units	93.3%	93.3%	98.0%	100%	96.0%	100%	86.0%	80.0%
Start Date	98.7%	100%	98.0%	100%	100%	100%	98.0%	100%
End Date	98.7%	100%	98.0%	100%	100%	100%	98.0%	100%
Population	98.0%	100%	96.0%	100%	100%	100%	98.0%	100%
Duration	95.3%	96.7%	98.0%	100%	100%	100%	88.0%	90.0%
Mode of Delivery	98.7%	100%	98.0%	100%	100%	100%	98.0%	100%
Minimum Staff Req.	83.3%	100%	94.0%	100%	80.0%	100%	76.0%	100%

Based on the results of both the claims review and the HSAG over-read audit, BHI considers all of the goals from FY13 to be met.

*Barrier analysis and interventions*

The primary barrier encountered in this year’s audit was the documentation system being previously utilized by the BHI drop in centers. As a part of the corrective action plan implemented by the BHI drop in centers as a part of the CY11 411 audit, BHI began using a new system for tracking drop in center encounters, Patient Tools. The Patient Tools program was designed in order to not only appropriately capture member encounters, but also meet all documentation requirements under the new H0023 Uniform Coding Standards. However, the timeframe captured by the CY12 Encounter Data Validation audit was prior to the implementation of the Patient Tools System. Therefore, BHI auditors had no choice but to review documentation of services that was known to be inadequate and had since been corrected.

Providers with an overall score below 95% were required to submit a Corrective Action Plan (CAP) addressing any deficiencies discovered during the audit. Each provider was given specific feedback on resolving issues such as system errors, clinical errors, or errors related to the USCS Manual. To address areas of deficiency, providers implemented corrective actions such as:

- Training with staff regarding proper definition and billing of various Prevention/Early Intervention codes
- Configuring EMRs to correctly calculate units for encounter codes
- Including staff credentials on all service templates in the EMR

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Encounter Data Validation (411) Audit	Improve provider claims review to a compliance score of 80% or higher (increase from 74%)	Continuing to train providers on proper billing and documentation practices	6/30/14
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	

## **Provider Audits**

### *Summary of project*

In FY13, BHI streamlined their provider audit process. BHI created an audit tool that combined several different elements, including claims and billing validation (with elements similar to the 411 audit), treatment plan requirements, and requirements for the full clinical records (such as releases of information, disclosure forms, components of an intake, etc.).

An audit is conducted to examine the quality and appropriateness of medically necessary services delivered to members, whether the services were billed accurately and supported through documentation in the medical records. The audit process is designed to identify a provider's compliance with applicable BHI, state and/or federal regulations governing the healthcare program and payment to the provider.

Providers are typically selected for audit using one or more of the following criteria: high volume of services provided, high cost services provided, new providers, as required for state and/or federal regulations, member inquiry or complaint, internal staff inquiry, and random selection.

In FY13, BHI completed audits on ten providers. Upon completion of the audit, BHI schedules a face-to-face meeting with the provider to discuss results, including areas of strength, suggestions for improvement and required actions. The required actions can include completing a corrective action plan (CAP), completing specific trainings on the deficit's identified through the audit, and possibly repayment of claims previously paid. Each provider is offered a training that is facilitated by BHI staff. Providers who do not pass the audit with a 95% will be required to complete a CAP.

### *Goal from FY13*

- Ensure that providers accurately document the services provided
- Conduct audit of treatment plans and documentation
- Monitor corrective action plan implementation and completion as applicable

### *Results and analysis*

BHI providers have been very responsive to the audit process. Providers appreciate the training being provided by BHI as a part of the corrective action process (often requiring entire clinical staff to attend), and having a QI contact within BHI for questions about coding and documentation. Several providers have revamped various templates, including progress note templates and treatment plan templates in order to meet compliance and prompt clinicians to meet all documentation standards.

Several patterns have emerged across provider compliance with these audits, particularly around minimum documentation. Clinicians most often struggle with citing the therapeutic interventions being utilized in the session, directly linking the service to the treatment plan, and specifically documenting process (or lack thereof) towards the specific treatment goals.

Table 15 demonstrates the various scores from provider audits as well as the primary deficiencies identified during the audit.

**Table 15: BHI provider audit results**

Provider	Initial Audit Score	Initial Audit - Primary Issues	Follow up Audit Score	Follow up Audit - Primary Issues
A	35%	Missing daily summary note for day treatment	78%	Missing durations, minimum documentation
B	61%	Missing progress notes, treatment plans outside timelines, minimum documentation	94%	Missing treatment plan signatures
C	47%	Missing treatment plans, no POS/duration on notes, incorrect procedure codes	*	Not yet scheduled
D	17%	Improper span billing, incorrect procedure codes, minimum documentation	*	Scheduled for 10/1/2013
E	83%	Incorrect diagnosis, missing signatures	*	No follow up audit scheduled
F	46%	Missing POS/duration, minimum documentation, treatment plan signatures	*	Scheduled for 1/1/2014
G	71%	Unbillable services, minimum documentation issues	*	Not yet scheduled
H	44%	Incorrect POS/unit calculation, missing credentials, missing signatures	*	Not yet scheduled
I	52%	Missing documentation/ treatment plans, missing POS	*	Scheduled for 1/1/2014
J	56%	Missing documentation/duration, minimum documentation, treatment plan signatures	*	Not yet scheduled

*Barrier analysis and planned interventions*

Because the process of regular auditing of providers is a fairly new process for BHI, there have been several barriers that have been encountered. Primarily, several providers have struggled with meeting with various deadlines (deadline for submitting records, for CAP submissions, etc.) Therefore, BHI has recently begun including specific deadlines in the requests letters as well as any possible consequences (including on-site audits or possible recoupments) for non-compliance with audit deadlines.

When BHI first began this process, results and corrective action requests were sent out via certified mail. This resulted in lots of confusion and questions from providers. Therefore, BHI began meeting with providers face-to-face to present results and discuss any necessary corrective action. This has not only been beneficial for provider relations, but has helped to clear up a lot of confusion about what is being required from the providers.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Provider claim/record audits	Improve provider documentation and reduce incidence of waste and abuse in billing practices	Continue to develop the audit process and educate providers about compliance requirements	6/30/14
		Initiate a minimum of 10 provider audits	

## **Performance Measures**

BHI believes that to provide truly excellent mental health services, programs should go beyond basic quality assurance. BHI strives to use data continually, to improve services, and develop innovative solutions where traditional methods have failed. Note that all performance measures are being reported for FY12, as FY13 Performance Measures will not be calculated until fall of 2013.

### **Reducing Cost of Care**

#### *Summary of project*

BHI utilizes a very skilled Utilization Management (UM) department whose focal point is to authorize the medical necessary appropriate level of care, in the least restrictive environment. BHI is able to achieve these outcomes by utilizing a UM department that actively manages the members admitted to inpatient hospitals. The UM Department also has a close relationship with the CMHC and CPN providers. This relationship allows the UM team to identify an outpatient service provider that will be the best fit for our members' unique mental health needs. The UM team also keeps records on frequent ED utilizers. Becoming familiar with our members who are high utilizers in the ED allows BHI to connect that member with the most appropriate outpatient provider.

The Office of Member and Family Affairs (OMFA) also provides programming to reduce member's ED utilization and inpatient hospital stays. Through initiatives like the peer specialist program and the Drop-in centers, OMFA is able to provide members with support, education, outreach, advocacy, and basic needs. These services help members reduce their need for hospitalization or the utilization of an ED. Drop-in centers provide a safe place where members can get their daily needs met, which reduces stress that can often times exacerbate a mental illness. The peer support program provided is crucial to many members living with a severe mental illness. Peer specialists understand the experience of being admitted to the hospital or utilizing an ED to cope with severe mental illness symptoms. With those experiences in mind, the peer specialists can empathize with the member and relate with real life solutions that can help the member avoid over utilization of EDs and/or inpatient hospital stays. Peer specialists are crucial in addressing concerns of our members that are the impetus for ED use and hospital stays.

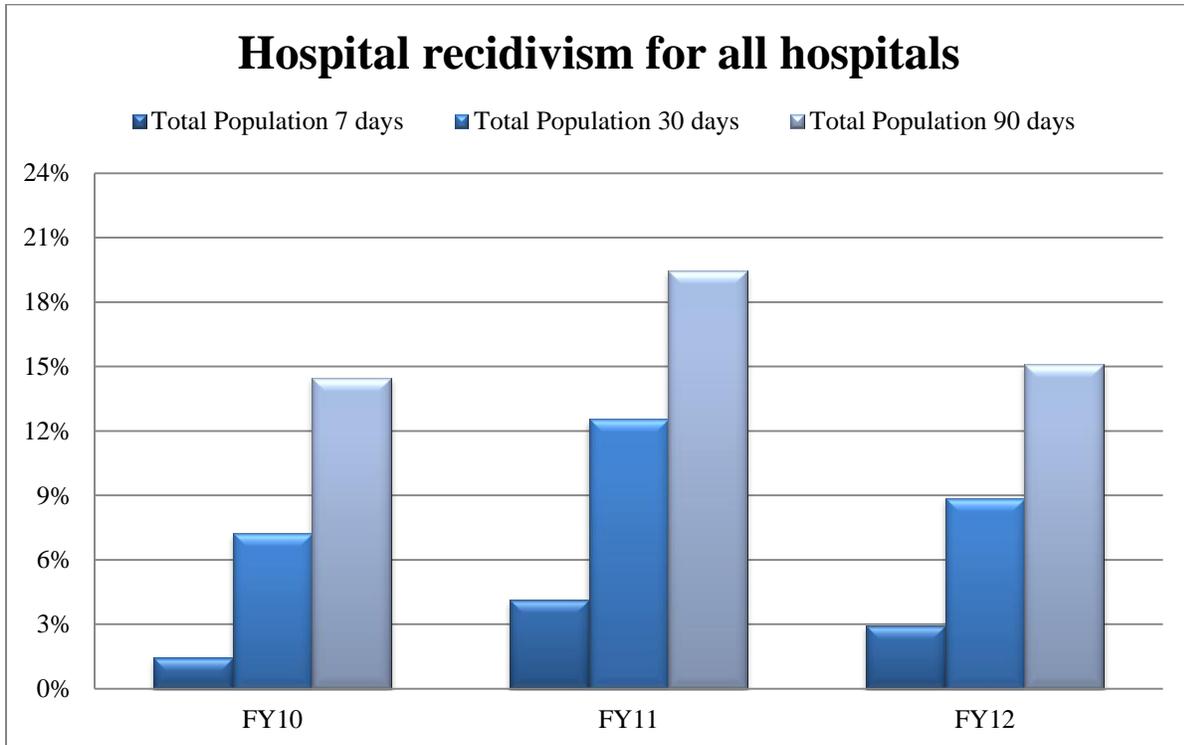
#### *Goals from FY13*

- Calculate Annual Performance measures as indicated in BHI-HCPF contract and monitor performance on measures
- Monitor patterns of over and under-utilization of services by BHI members, conduct gap and panel analysis on a quarterly basis to identify over and under utilization
- Report, review, and analyze Inpatient Admissions, Discharges, Length of Stay, and Recidivism quarterly to the UM Committee. Examine utilization patterns for individuals in selected populations
- Monitor for patterns of over utilization of emergency services

*Results and analysis – Hospital Readmissions*

BHI calculates the proportion of member discharges from a hospital episode and those members who are readmitted for another hospital episode within 7, 30, 90 days. This measure is calculated by HEDIS age group and by hospital type (non-state hospital and all hospital). Figure 4 shows the number percentage of members who were readmitted to the hospital within 7, 30, and 90 days of discharge from another hospital stay. In FY12, BHI reduced recidivism in each of the three timeframes.

**Figure 4: Hospital recidivism**

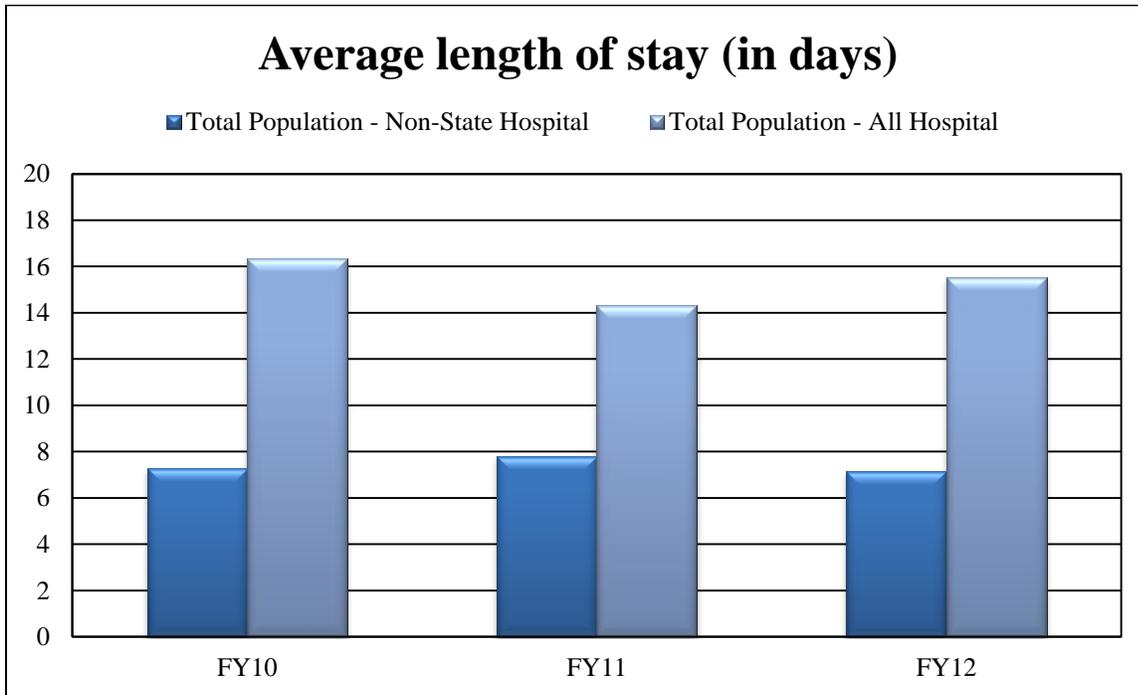


*Results and analysis – Length of Stay*

This indicator measures the average length of stay (ALOS, in days) for BHO members discharged from a hospital (non-state and state hospital) episode by age group and total population. For members transferred from one hospital to another within 24 hours, total length of stay for both hospitals is attributed to the hospital with the final discharge. For final discharges from a State hospital, all days in the hospital episode will be included if the member was Medicaid eligible at the time of admission. Because inpatient stays in state hospitals tend to be disproportionately longer than those of non-state hospitals, Figure 5 shows the average length of stay for all hospitals (both state and non-state) as well as the average length of stay for non-state hospitals alone.

Although BHI demonstrated a slight increase in ALOS for all hospitals, BHI performed at a slight decrease in non-state hospitals by focusing on treating members in the least restrictive environment.

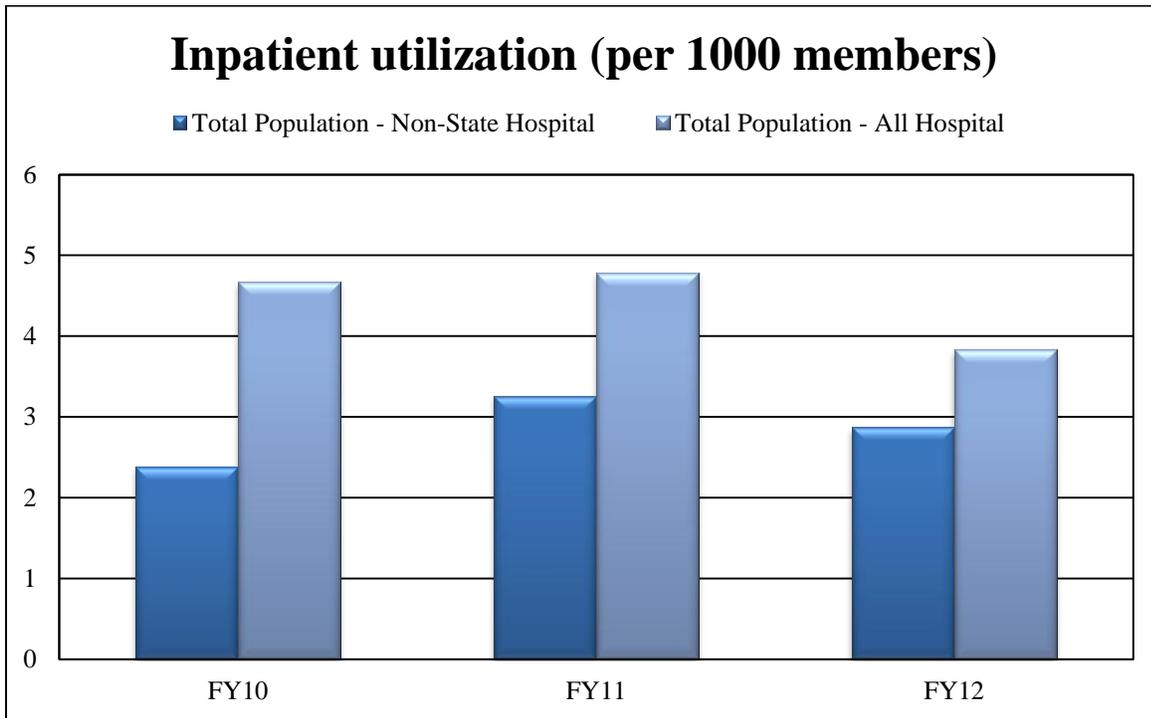
**Figure 5: Average length of stay**



*Results and analysis - Inpatient Utilization*

This indicator measures the total number of BHO member discharges from a hospital episode for treatment of a covered mental health disorder per 1000 members. Again, because the UM department continues to build relationships with providers at all levels of care, BHI has increased the utilization of other sub-acute levels of care, thereby decreasing inpatient utilization, as demonstrated in Figure 6.

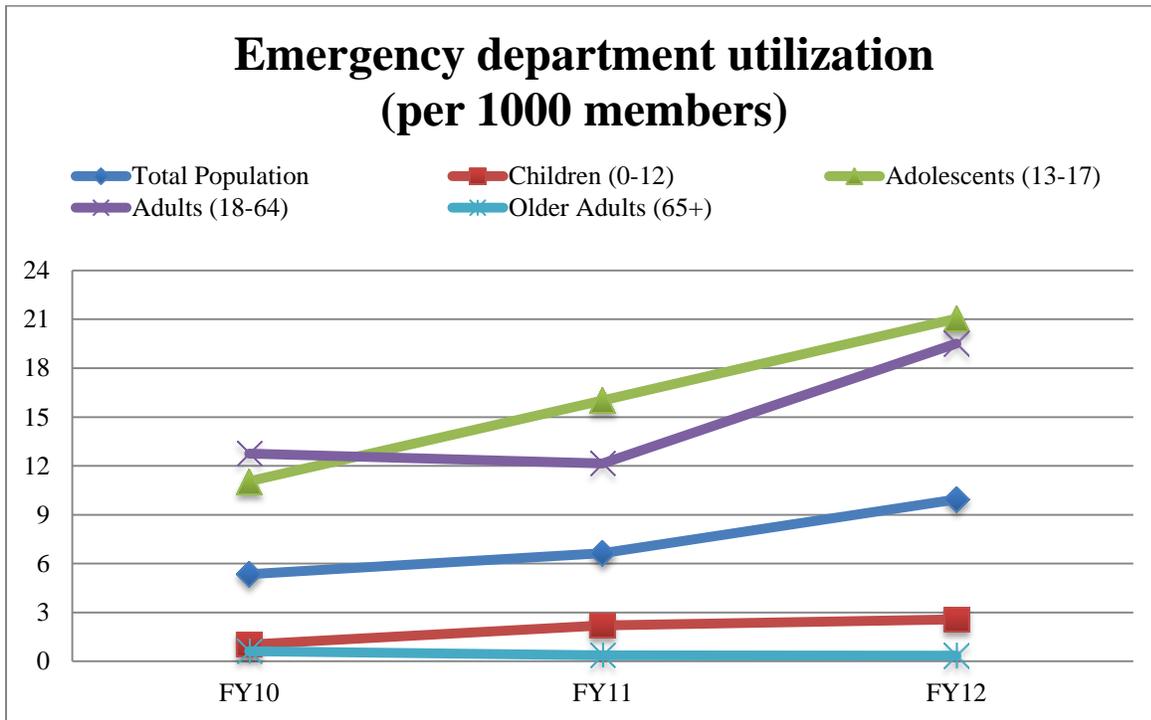
**Figure 6: Inpatient utilization**



*Results and analysis – ED Utilization*

This indicator measures the number of BHO member emergency room visits for a covered mental health disorder per 1,000 Members by age group and overall for the specified fiscal year 12-month period. While BHI experienced an increase in ED use by adults, and adolescents and in an overall total (as seen in Figure 7), these increases were proportional to that experienced by other BHOs across the state.

**Figure 7: ED utilization rates by age category**



*Barrier analysis and planned interventions*

In an effort to obtain more timely data and see more timely effects of interventions, BHI has begun measuring each of these indicators on a quarterly basis for reporting in the Quarterly Performance Report Card. The BHI UM Department will continue to monitor all those admitted to an inpatient or ED level of care. The BHI QI Department will continue to measure these indicators on a quarterly basis to determine the short and long-term effects of the various interventions from the UM Department.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Reducing Cost of Care	Continue to perform at or above the statewide BHO average for cost-of-care performance measures.	Continue to measure performance indicators quarterly to monitor for patterns and trends across services	6/30/14
		Continue to monitor specific member utilization for targeted interventions	
		Continue to develop peer specialist program to assist in interventions	

## Improving Member Health and Safety

### Summary of project

There are several statewide performance measures designed to monitor member health and safety, particularly regarding psychotropic medications. BHI furthered this study in the recent selection and design of the Performance Improvement Project (PIP). For more information, see page 60.

### Goals from FY13:

- Calculate Annual Performance measures as indicated in BHI-HCPF contract
- Monitor performance on measures

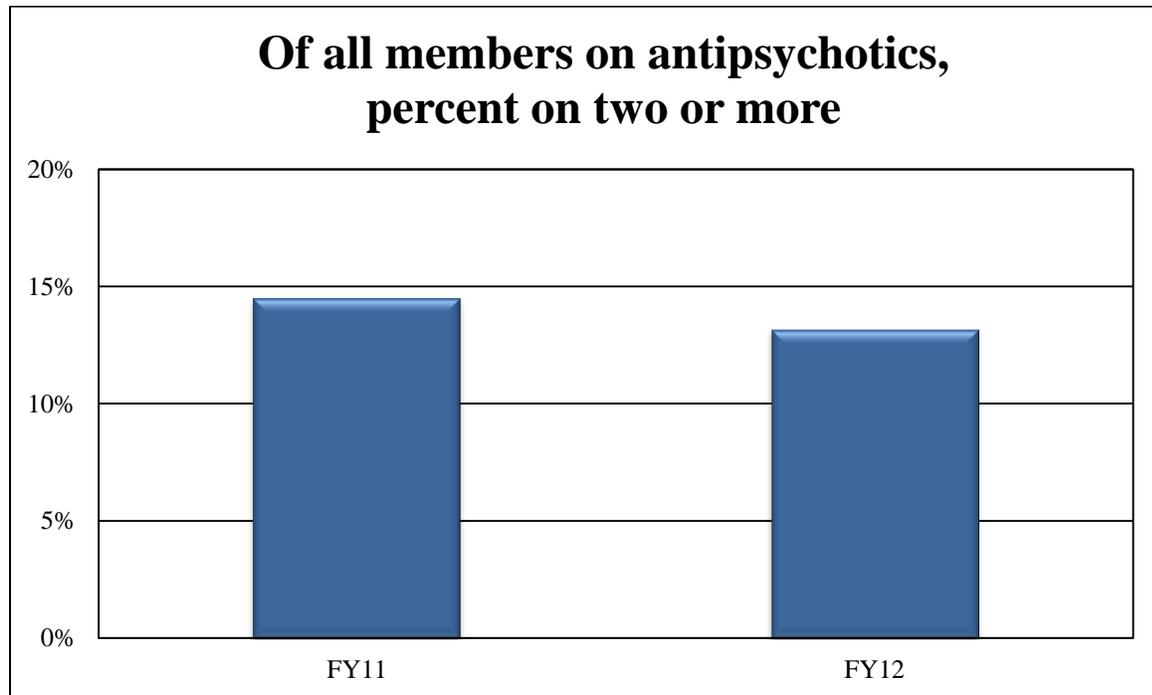
### Results and analysis – Adherence to atypical antipsychotics

This indicator measures the percentage of members 19-64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period. BHI will be measuring this for the first time during the FY13 performance measures calculations; therefore, no results for FY 12 are available.

### Results and analysis – Percentage with duplicate antipsychotic

Certain clinical circumstances allow members occasionally to be prescribed two or more atypical antipsychotic medications at the same time. This indicator measures those members prescribed multiple atypical antipsychotic medications (for 120 days or more) in proportion to members who are prescribed only one atypical antipsychotic. BHI demonstrated a slight decrease from FY11 to FY12 in this measure, as demonstrated in Figure 8.

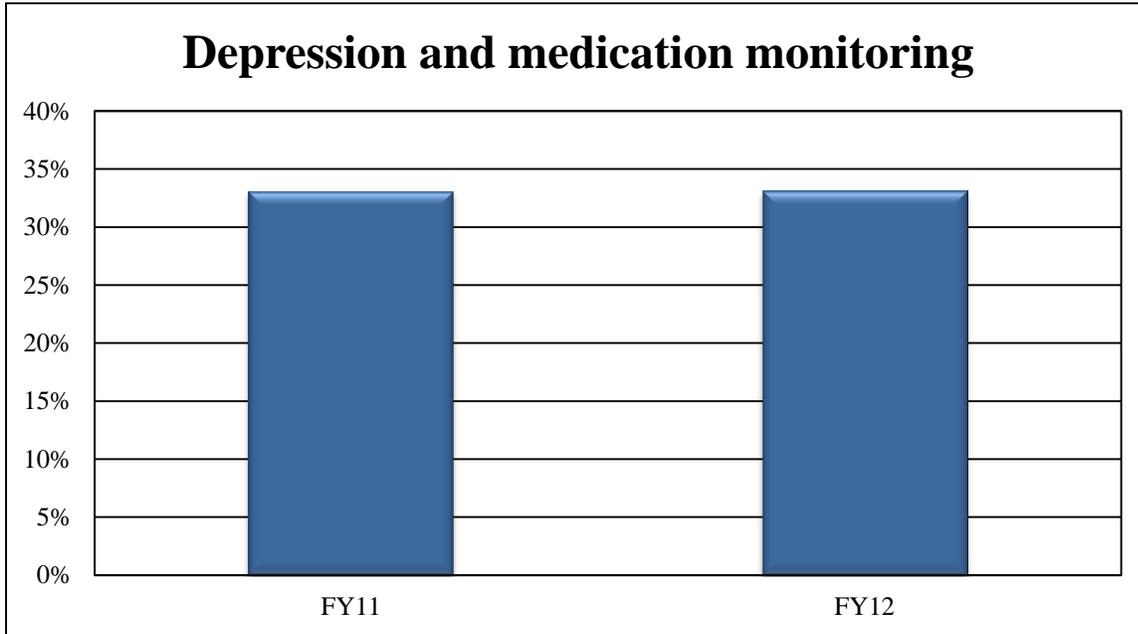
**Figure 8: Of all members on antipsychotics, percent on two or more**



*Results and analysis - Depression and Medication*

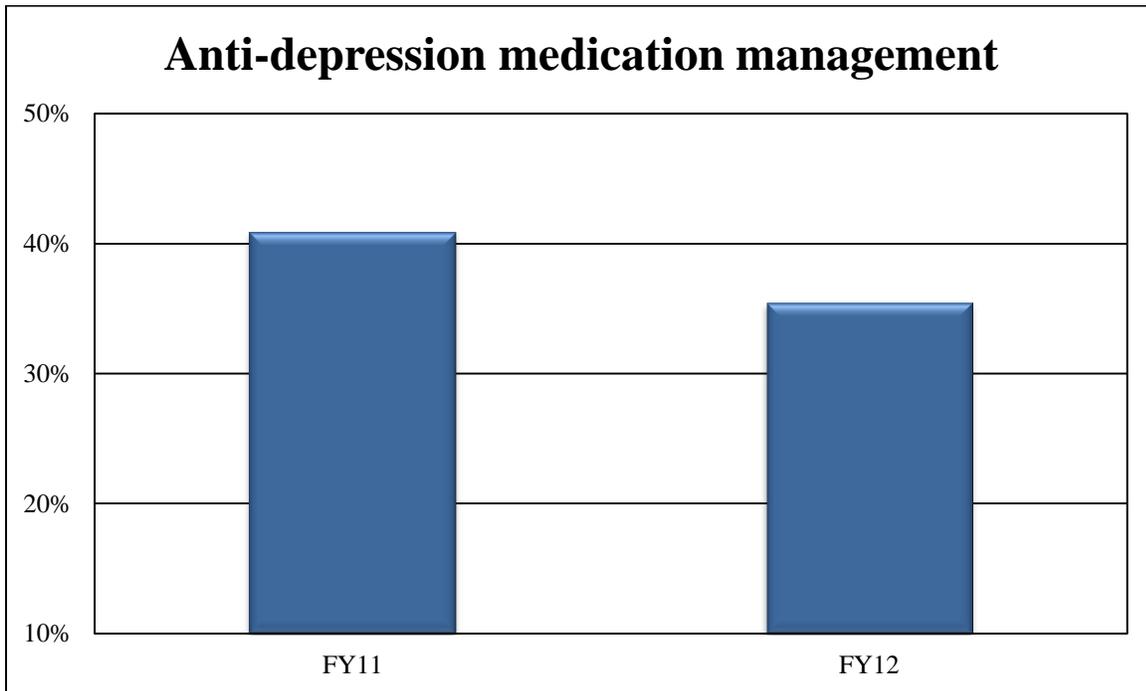
This indicator measures the percent of members who have been: 1) diagnosed with a new episode of major depression, 2) treated with antidepressant medication, and 3) maintained on antidepressants for at least 84 days (12 weeks). As demonstrated in Figure 9, BHI showed little change from FY11 to FY12. BHI also performed below the statewide BHO average.

**Figure 9: Depression and medication monitoring**



*Results and analysis - Anti-depression Medication Management and optimal practitioner contacts*  
 This indicator measures the percent of members diagnosed with a new episode of major depression, treated with antidepressant medication, and who had at least 3 follow up contacts with a practitioner during the acute treatment phase (84 days or 12 weeks). As shown in Figure 10, BHI demonstrated a slight decrease in performance from FY11, yet continued to perform above the statewide average for this measure (28.80%).

**Figure 10: Anti-depression medication management**



*Barrier analysis and planned interventions*

Because these measures are calculated on an annual basis and often several months following the end of the fiscal year, targeted and timely interventions are difficult. Therefore, BHI will assess if these measures can be calculated on a quarterly basis as to better measure the impact of targeted interventions. In addition, BHI plans to provide education around these measures to the psychiatric providers in the network.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Member Health and Safety	Perform at or above the statewide BHO average for the member health and safety performance measures.	Assess need for quarterly calculation of performance measures to better target interventions.	1/1/14

## **Coordination of Care – Follow-up after Hospital Discharge**

### *Summary of project*

It is important to provide regular follow-up treatment to members after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the member's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care. Research has found that member access to follow-up care within 7 days of hospital discharge from hospitalization for mental illness to be a strong predictor of a reduction in hospital readmission. Facility treatment may stabilize individuals with acute behavioral conditions, but timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital. The period immediately following discharge from inpatient care is recognized as a time of increased vulnerability. Ensuring continuity of care by increasing compliance to outpatient follow up care helps detect early post-hospitalization medication problems and provides continuing support that improves treatment outcomes and reduces health care costs.

Follow up after hospital discharge is a yearly performance measure that is calculated by BHI. The measure is the percentage of member discharges from an inpatient hospital episode for treatment of a covered mental health disorder to the community or a non-24-hour treatment facility and were seen on an outpatient basis (excludes case management) with a mental health provider within 7 or 30 days after discharge. Readmissions within that time frame are excluded. In Fiscal Year 2011 (FY11), BHI providers completed follow up appointments within 7 days 50.0% of the time, and within 30 days 67.6%. In FY12, BHI increased performance to 57.7% and 70.8% (7 days and 30 days, respectively).

Although BHI has shown an increase in performance from FY11 to FY12, performance is not what BHI would consider optimal. BHI has decided to review the measure quarterly to help improve systematic issues in transition of care and improve member safety efforts. Some possible interventions to improve this measure could include structured discharge communication, member education, involvement of the BHI Health Coordinators, and coordination of a member's medications.

### *Goal from FY13*

While no goal was identified in last year's Quality Improvement Work Plan, BHI added a goal of improving this specific performance measure to meet or exceed internal benchmarks of 90% compliance (for 7-day follow up) and 95% compliance (for 30-day follow up).

### *Results and analysis*

Through several targeted interventions involving data collection and data quality improvement, BHI was able to effectively measure this indicator on a quarterly basis. Due to the design of the measure, performance cannot be assessed until quarter following the measurement period, to allow time for follow up appointments to occur for hospital discharges that occur at the end of the measurement period.

**Table 16: 7-day follow-up after hospital discharge**

Measurement Period	Measurement	Numerator	Denominator	Compliance	Benchmark
FY11	Baseline	139	278	50.00%	90.00%
FY12	Re-measurement 1	180	312	57.69%	90.00%
FY13, Q1	Re-measurement 2	47	89	52.81%	90.00%
FY13, Q2	Re-measurement 3	43	79	67.14%	90.00%
FY13, Q3	Re-measurement 4	47	70	69.23%	90.00%

**Table 17: 30-day follow-up after hospital discharge**

Measurement Period	Measurement	Numerator	Denominator	Compliance	Benchmark
FY11	Baseline	188	278	67.63%	95.00%
FY12	Re-measurement 1	221	312	70.83%	95.00%
FY13, Q1	Re-measurement 2	62	89	69.66%	95.00%
FY13, Q2	Re-measurement 3	56	79	87.14%	95.00%
FY13, Q3	Re-measurement 4	61	70	82.05%	95.00%

While BHI continues to perform above the statewide BHO average for this measure, performance continues to fall short of the new internal benchmarks set by the QI and UM departments. However, due to the substantial increase in compliance in FY13 Q3, BHI is confident that continued analysis and targeted interventions will assist BHI's performance on this measure and performance will meet benchmarks during FY14.

#### *Barrier analysis and interventions*

During FY11-FY12, the responsibility for coordination of care sat with the CMHCs as they authorized inpatient services as well and provided a majority of the follow up care. This often resulted in communication barriers between each of the CMHCs, the various inpatient providers, and BHI and complicated oversight. This contributed the decision made by BHI to no longer delegate inpatient authorizations to the CMHCs, effective September 1, 2012.

The yearly calculation of this measure, combined with the time delay in calculating the measure also complicated the timely implementation of interventions. To address this barrier, BHI began calculating this measure on a quarterly basis. BHI has decided to review the measure quarterly to help improve systematic issues in transition of care and improve member safety efforts. These measures were calculated on a quarterly basis for the first time in FY13, Q1 (analyzed in January 2013). Although this quarter demonstrated an increased from baseline, BHI still failed to meet the benchmark and comparison goals.

At this time, the Utilization Management department has a team of nurses performing the inpatient authorizations. The UM department began tracking member hospitalizations and authorizations in a spreadsheet to have more accurate, real-time data. However, the spreadsheet was a work-in-progress and at first, did not contain much information about the member's follow up appointments. This made it difficult to follow up with providers and/or members about whether or not the follow up appointment was attended. By the end of Q1, the UM department added several data elements to their spreadsheet, including names of hospital liaisons, the date of the follow up appointment, and the facility/clinician providing the follow up appointment.

In April 2013, data from FY13, Q2 was analyzed. This analysis cycle demonstrated continued decreases in performance in most areas. This measure was discussed at length in the Performance Evaluation and Outcomes Committee (PEO), with the Quality Improvement Directors from each of the CMHCs. Both method of data collection and barriers to better performance were discussed. CMHCs expressed confusion about the inclusions and exclusions of the measure. BHI provided education about the procedure codes that are included as follow up appointments (e.g., case management appointments are excluded, but screenings, intakes, and therapy appointments are included). Each CMHC plans to focus on increasing communication between hospital liaisons and utilization management staff, and the development of an internal tracking mechanism to better track members from hospital to follow-up. Because some of the follow-up appointments occurred in January 2013, this measure was affected by the change in CPT codes that went into effect January 1, 2013. However, this was only a change in data pull and SQL codes, and the methodology was not truly affected.

To date, BHI has discussed additional interventions to help improve this measure. The QI and UM departments have been working together to develop better oversight of actual follow up appointments. The UM department has begun tracking even more specific information about a member’s follow-up appointment (type of appointment, etc.) and is conducting follow up phone calls with the service provider to assure that the appointment took place. If the appointment did not take place, the provider will be given a specific script to conduct an outreach follow-up call with the member to assess barrier to treatment and attempt to reschedule the appointment.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Coordination of Care – Follow-up after hospital discharge	Provide 90% of outpatient appointments within 7 days after hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/14
	Provide 95% of outpatient appointments within 30 days of hospital discharge		

## **Coordination of Care - Improving Physical Healthcare Access**

### *Summary of project*

Physical healthcare access is defined by the total number of Members who received outpatient mental health treatment during the measurement period and had a qualifying physical healthcare visit during the measurement period.

In an effort to provide effective preventive behavioral health programs, BHI recognizes the need to integrate medical and psychosocial health. The solution was to create a Care Management program that promotes behavioral wellness by addressing, stabilizing, and preventing decline in its members' physical health. A majority of the population BHI serves has co-occurring chronic mental and physical illness such as diabetes, bipolar disorder, asthma, heart disease, COPD, and schizophrenia. The goal of the Care Management program is to eliminate barriers members face when navigating the healthcare system and, thus, enabling them to better care for themselves—both mind and body. BHI acknowledges the connection between the quality of one's physical health and their ability to maintain mental stability. The BHI Care Management program seeks to ensure the mental health of its members by improving their overall health; therefore, reducing costs for both behavioral and physical healthcare.

The Care Management program serves adult Medicaid recipients and their families by partnering with the local CMHC. The Care Management program has Health Coordinators placed at each CMHC to provide optimal access to members in need of these services. These members come from a wide variety of cultural backgrounds and primarily fall between the age ranges of 18-64. This population includes Hispanics, Caucasians, African Americans, and many refugees from African and Asian countries. Unfortunately, many of these members do not have the support they need to address effectively physical and mental health conditions. As a result, they do not receive treatment for long periods, resulting in multiple emergency department (ED) visits, inpatient hospital stays, and often a decline in their mental health. The role of the BHI Health Coordinator is to connect members to appropriate physical health care, improve communication between all providers involved in a member's care, and prevent further decline in a member's physical and behavioral health.

There are many ways BHI Health Coordinators work to connect members to appropriate medical care. BHI Health Coordinators provide members with referrals to PCPs and specialists in their catchment area. If a member is unable to do so themselves, the coordinator will also schedule appointments and make transportation arrangements. Linking each member to a PCP allows him or her to establish a Medical Home with access to ongoing and preventative care reducing the need for ED visits and inpatient hospital stays. The Health Coordinator receives referrals from therapists, Case Managers, and prescribers within the CMHCs. The Health Coordinator also reviews claims data and contacts members who are considered high utilizers of hospital resources. In these cases, if the member is not already connected to their local CMHC, the Health Coordinator will make a psychiatric referral, if appropriate.

Once a member is connected to a PCP or specialist, the Health Coordinator continues a documented process. Upon written permission from the member, the Health Coordinator seeks to ensure that all parties involved in the member’s medical care are aware of all interventions. This includes facilitating the release of records, making sure all providers have access to lab results, current medication lists, and most importantly, increasing communication between physical and mental health care providers. Communication between physical and behavioral health care providers is paramount to maintaining a member’s psychiatric stability and preventing future decline.

*Goal from FY13*

Improve coordination of care with medical providers.

*Results and analysis*

This performance measure is calculated by HCPF. Because this is a new indicator, no trended performance is available. BHI will continue to monitor this measure and implement interventions to increase performance. Table X below shows BHI performance in FY12 (FY13 data not yet available, will be calculated in fall 2013). As BHI’s performance meets the statewide BHO average, BHI considers this objective met.

**Table 18: Percentage of BHI members with a physical healthcare visit**

<b>Total number of unduplicated members who had at least one BHO outpatient service claim/encounter during the measurement period. Members must be Medicaid eligible and enrolled at least ten months with the same BHO during the 12-month measurement period (denominator).</b>	12,124
<b>Total number of members from the denominator with at least one preventive or ambulatory medical visit (numerator)</b>	8,828
<b>BHI Performance</b>	72.81%
<b>Statewide BHO average</b>	72.80%

*Barrier analysis and planned interventions*

Coordination of care between behavioral health providers and medical providers continues to be an important focus for BHI. Based on the above information alone, it is difficult to create targeted interventions to improve performance. Therefore, BHI is working with providers to create a quarterly performance indicator to measure the percentage of clients with a primary care physician (PCP) as to better target and assist those members without a PCP in getting linked with one.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care	Continue to develop the Care Management Program	6/30/14
	Improve measurement of coordination of care	Develop Quarterly Performance Measure to identify the percentage of members receiving services who are linked with a PCP	1/1/14

## Improving Member Functioning

### Summary of Project

The Recovery Model focuses on empowering members not only in relation to their illness, but also for members to take charge of their entire lives. Therefore, two performance measures focus on improving overall member functioning, as measured by their living status.

### Goals from FY13

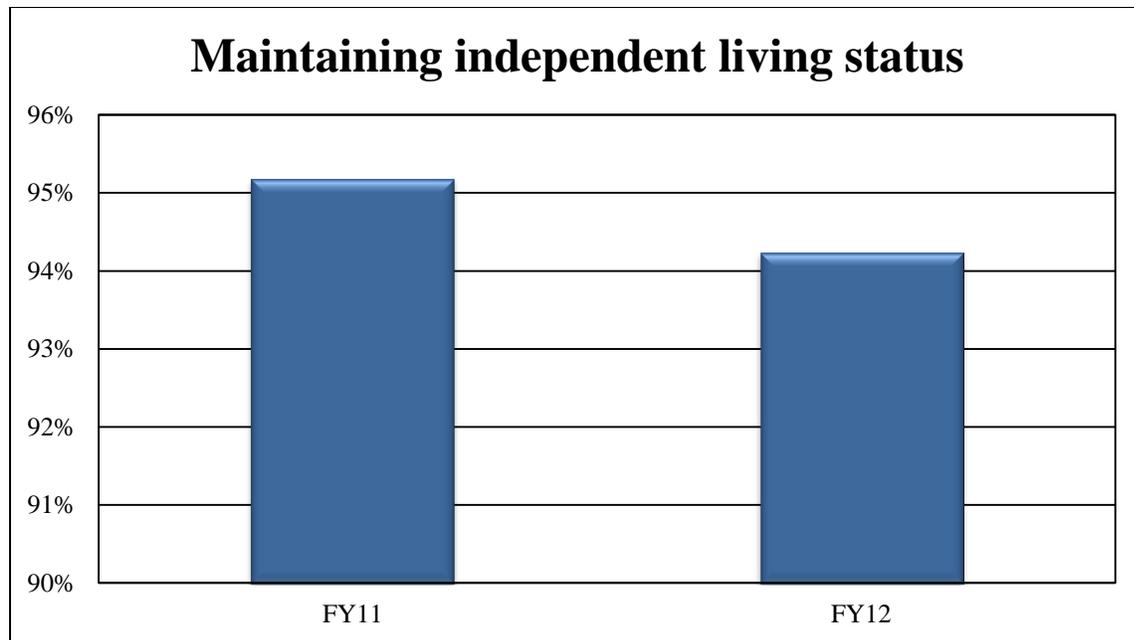
- Calculate Annual Performance measures as indicated in BHI-HCPF contract
- Monitor performance on measures

### Results and analysis

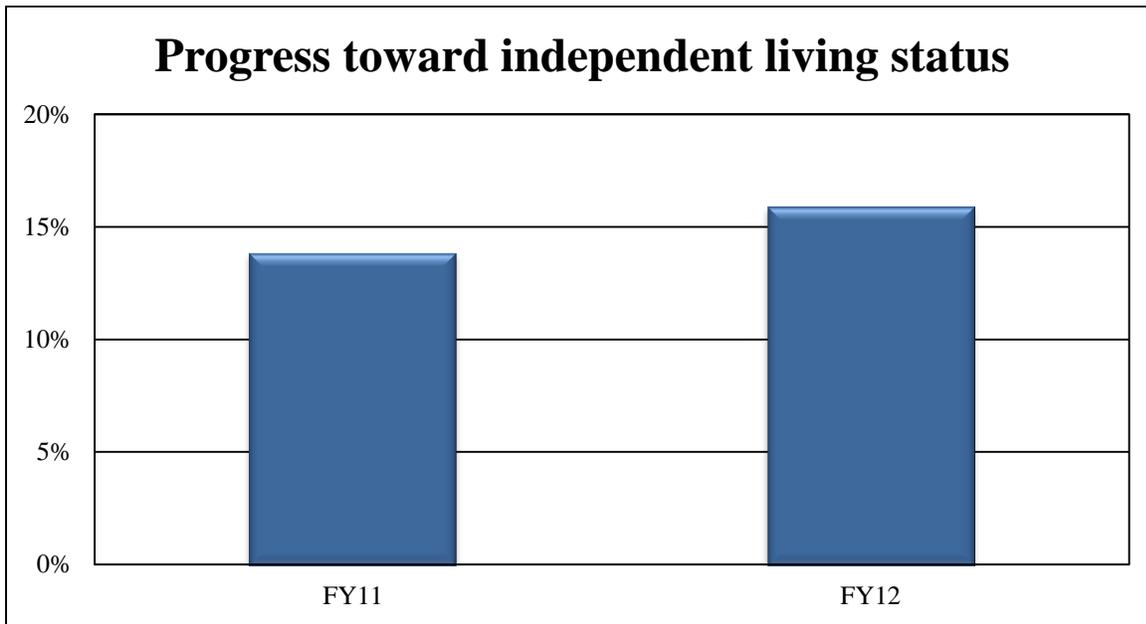
The Independent Living Status indicator measures the percent of clients, age 18 years and older, living independently, that maintain this status during the measurement period. The progress towards Independent Living Status indicator measures the percent of clients, age 18 years and older, who move to a less restricted place of residence, including independent living, during the measurement period. BHI performance on these measures is reflected in Figure 11 and Figure 12.

While BHI performance on the first measure decreased slightly, it remains consistent with the statewide average for this measure. In addition, the increase in performance in the second indicator is not only substantially higher than the statewide average (and an increase in BHI performance from FY11), but could also indicate that while fewer members maintained independent living status, an increased number of members moved towards independent living during FY12.

**Figure 11: Members maintaining independent living status**



**Figure 12: Members making progress towards independent living status**



*Barrier analysis and planned interventions*

Performance measures such as these are difficult to assess for proper benchmarks and goals. While optimistic to believe that 100% of members receiving services could be living independently, this goal would be unrealistic. It is therefore difficult to distinguish an appropriate percentage of members who “should” be living independently and/or making progress towards independent living. Therefore, BHI will continue to monitor these measures over time and assess the need for intervention on a case-by-case basis if negative trends emerge.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Improving Member Functioning	Continue to measure and monitor performance	Cooperate with HCPF on the calculation of performance measures	6/30/14

## **Information Systems Capabilities Assessment Tool (ISCAT) Audit**

### *Summary of project*

Each of the performance measures that are calculated for BHI is subject to validation by HSAG. Some of these measures were calculated by HCPF using data submitted by the BHOs; other measures were calculated by the BHOs. The measures came from a number of sources, including claims/encounter and enrollment/eligibility data.

The CMS Performance Measure Validation Protocol identifies key types of data that should be reviewed as part of the validation process. Below is a list of the types of data collected and how HSAG conducted an analysis of this data:

- Information Systems Capabilities Assessment Tools (ISCATs) were requested and received from each BHO and the Department. Upon receipt by HSAG, the ISCATs were reviewed to ensure that all sections were completed. The ISCATs were then forwarded to the validation team for review. The review identified issues or items that needed further follow-up.
- Source code (programming language) for performance measures was requested and was submitted by the Department and the BHOs. The validation team completed query review and observation of program logic flow to ensure compliance with performance measure definitions during the site visit. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- Performance measure reports for FY 2011–2012 were reviewed by the validation team. The team also reviewed previous reports for trends and rate reasonability.
- Supportive documentation included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. All supportive documentation was reviewed by the validation team, with issues or clarifications flagged for further follow-up.

### *Goal from FY13*

- To coordinate with HSAG to validate performance measures identified by HCPF. This will include evaluation of accuracy, validation to the extent to which Medicaid-specific performance measures calculated by BHI followed specifications established by HCPF
- Submit ISCAT on BHI's policies, processes, and data to provide necessary background information needed for on-site data validation activities
- Coordinate with HSAG to complete on-site review of performance measures according to CMS regulations

*Results and analysis*

BHI achieved “met” status for all elements reviewed, resulting in a 100% compliance score. The strengths and suggested areas of improvement include:

- Strengths:
  - BHI continued to have a very collaborative relationship with Colorado Access, its administrative service organization (ASO).
  - BHI collaborated with the BHOs and the Department in acting on the recommendations from the previous year’s audit to revise the scope document.
  - BHI maintained a team of experienced professionals who work together to ensure robust and accurate performance measure reporting.
- Suggested areas of improvement:
  - BHI should continue to work with the Department and other BHOs to address and resolve issues identified in the scope document, such as clarifying the type of mental health practitioners required and required diagnoses for select measures.
  - BHI should implement a rate validation process to ensure accurate rates. This process should include checking the source data using various data sorts to ensure that proper date ranges and codes are used, as well as ensuring all data for the review period have been included.
  - It was identified during the site visit that one individual was responsible for the performance measure rate calculation process. BHI should implement a process to provide additional staff as backup for this process.
  - As Colorado Access begins the transition of its claims processing to a new transactional system, BHI should make sure that this process is thoroughly documented, including any issues encountered along the way and how those issues were resolved.

*Barrier analysis and planned interventions*

BHI has not encountered any barriers in implementing the areas of improvement suggested by HSAG. Therefore, each of the interventions above has been implemented effectively.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Information Systems Capabilities Assessment Tool (ISCAT) audit	Continue to achieve 100% compliance on the audit by	Continue to monitor and assess each aspect of the performance measure calculation process and adjusting accordingly	6/30/14

## Clinical Practice Guidelines and Evidence-Based Practices

### Practice Guideline Review and Development

#### *Summary of project*

BHI adopts practice guidelines that meet the following criteria as required by the Medicaid contract and federal managed care regulation:

- The guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- The guidelines take into consideration the particular needs of BHI members
- The guidelines have only been adopted after consultation with appropriate contracted health care and mental health professionals
- The guidelines are reviewed and updated periodically as appropriate

BHI reviews, updates, and implements practice guidelines through our Standards of Practice Committee (SOP), comprised of the following members:

**Table 19: SOP committee members**

<b>SOP Chairperson: BHI Chief Medical Officer</b>			
<b>ADMHN</b>	<b>AUMHC</b>	<b>CRC</b>	<b>BHI</b>
Medical Director	Medical Director	Medical Director	Chief Medical Officer
Clinical Supervisor of Child and Family	Director of Quality Improvement	Senior Manager of Child Development Center	Manager of Quality Improvement

Upon approval from the SOP Committee, BHI distributes the new or updated practice guidelines to providers in the following manners:

- To all the CMHC providers through the SOP, PEO, and PAC committees
- To the CPN providers through the provider bulletin or individual mailings/emails
- Posting on the BHI website

#### *Goals from FY13*

- Develop or adopt practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals
- Develop/adopt practice guidelines in consideration of the needs of members

#### *Results and analysis*

Table 20 below indicates the current BHI practice guidelines, including which guidelines have been newly implemented, recently reviewed, or remain ongoing. BHI also revised the current practice guideline policy to reflect NCQA standards for the creation and periodic review of practice guidelines. Because NCQA requires that practice guidelines are updated every two years (rather than the HCPF requirement of updating “as appropriate,”) BHI has been working hard to review existing practice guidelines to remain in compliance with NCQA standards.

**Table 20: Current BHI practice guidelines**

Practice Guideline	New implementation	Reviewed in FY13	Remain ongoing
Atypical Antipsychotics: Monitoring for Metabolic Side Effects		X	
Psychosocial Treatment of Bipolar Disorder			X
Eating Disorders			X
Risk Assessment		X	
Eye Movement Reprocessing and Desensitization (EMDR)		X	
Developmental Disabilities and Mental Illness			X
Reactive Attachment Disorder	X		
Obsessive Compulsive Disorder	X		
<b>Medication Algorithms</b>			
Attention Deficit Hyperactivity Disorder (ADHD)			X
ADHD with Intermittent Explosive Disorder			X
ADHD and Major Depressive Disorder			X
ADHD with Tics			X
Antipsychotics			X
Antipsychotic movement Disorders and Co-existing Symptoms			X
Bipolar Disorder			X
Major Depression			X

*Barrier analysis and planned interventions*

In FY12, BHI had combined the PEO and SOP Committees into one committee. Due to the intensive workloads of both committees, BHI made the decision to divide the committees once again as to increase the efficiency of both committees. However, scheduling a regular meeting time proved to be difficult for several reasons:

- The Chief Medical Officer and Medical Directors from each of the CMHCs typically have very full schedules, including client appointments and several other meetings and tasks, therefore finding an agreed upon meeting time was difficult
- Committee members come from locations all over the Denver metro area, often resulting in a 30-45 minute commute to meetings

Therefore, BHI decided to hold all SOP meetings via teleconference. This allows for better attendance as no commute is required and results in less of a burden on committee member schedules.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Clinical Practice Guidelines	Develop and implement practice guidelines to meet the clinical needs of members and improve consistency across providers	Develop or adopt practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals	6/30/14
		Review all current practice guidelines every 2 years (or as necessary)	

## Practice Guideline Compliance – EMDR

### *Summary of project*

BHI recently encountered records of a provider using Eye Movement Desensitization Reprocessing (EMDR) with a client that clearly met exclusion criteria. This prompted the Quality Improvement (QI) team to investigate provider knowledge of the BHI practice guidelines, beginning with the EMDR guidelines. The EMDR Practice Guideline was first created in 2007 and includes specific guidelines for inclusion criteria, exclusion criteria, and supervision requirements for EMDR services.

Because EMDR does not have its own procedure code for claims, BHI had no way to complete a traditional claim data pull to investigate the number of unique members receiving EMDR services. However, the BHI has a database of information about our providers outside of the CMHCs (called our Contracted Provider Network – CPN), which includes a list of providers certified in EMDR. The EMDR supervisors at each of the CMHC were also contacted to obtain a list of EMDR certified providers at the CMHCs. Each EMDR providers was then contacted and asked to complete a brief questionnaire about the members receiving EMDR and their evaluation process.

Questionnaire items included:

- List of clients currently receiving EMDR
- For which symptoms or diagnoses do you use EMDR?
- What do you use as inclusion criteria when evaluating appropriateness for EMDR?
- What do you use as exclusion criteria when evaluating appropriateness for EMDR?
- What kind do supervision do you do around your EMDR cases?
- How do you inform clients about the risks and benefits of EMDR?
- What training have you completed for EMDR?
- Did you know that BHI has practice Guidelines for things like EMDR and the treatment of other mental health diagnoses?

### *Goal from FY13*

As this became a new initiative in December 2012, there was no goal set at the beginning of FY13. Due to NCQA standards, BHI now has a goal to measure compliance with at least two important aspects of at least two clinical practice guidelines

### *Results and analysis*

Provider responses to the questionnaire were entered into an Excel spreadsheet and scored according to compliance with the BHI practice guideline. It is noteworthy that BHI has over 80 providers in our CPN that are certified in EMDR. However, only providers *currently* providing EMDR services were surveyed.

Of the 35 clinicians currently providing EMDR services, 22 responded to the phone survey. Only 17 providers surveyed (77.3%) were aware that BHI publishes practice guidelines on specific diagnoses and treatment modalities. Table 21 demonstrates the compliance with the BHI guidelines by provider. Table 22 demonstrates compliance for each component of the BHI guidelines.

**Table 21: Provider compliance with EMDR practice guidelines**

Provider Number	Compliance Percentage	Provider Number	Compliance Percentage	Provider Number	Compliance Percentage
1	30%	9	90%	17	80%
2	70%	10	60%	18	50%
3	90%	11	90%	19	80%
4	80%	12	70%	20	100%
5	60%	13	100%	21	80%
6	80%	14	70%	22	100%
7	60%	15	70%	<b>Average</b>	<b>75%</b>
8	60%	16	80%		

**Table 22: Compliance by component of EMDR guideline**

Component	Compliance Percentage
Symptoms/Diagnoses	95.5%
Inclusion Criteria	45.5%
Exclusion Criteria	40.9%
Licensing, Training, and Supervision	93.2%
Informed Consent	100.0%
<b>Overall</b>	<b>75.0%</b>

Based on the results of the provider survey, it is clear that clinicians are least familiar with the inclusion and exclusion criteria for providing EMDR services. The clinicians who scored below 70% also stated that they were unfamiliar with BHI guidelines for EMDR. It also appears that some of the lower-scoring providers are clinicians in BHI’s CPN.

*Barrier analysis and planned interventions*

It became clear through this QI activity that many of our EMDR providers (particularly those in the CPN) are unfamiliar with the BHI EMDR practice guideline, as well as BHI practice guidelines in general. Therefore, BHI has begun emphasizing all practice guidelines, particularly new and newly revised guidelines, in the quarterly provider bulletin. For practice guidelines that are relevant to a subset of providers (such as the EMDR guideline), BHI will either mail or email a copy of the revised guideline to the provider directly, rather than only referring them to the website to view/print the new guideline.

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Compliance with Clinical Practice Guidelines	Increase oversight of providers’ compliance with BHI clinical practice guidelines	Revise the EMDR practice guideline to reflect current evidence-based practices and distribute to all EMDR providers	9/1/13
		Continue to monitor compliance with at least two important aspects of at least two clinical practice guidelines	6/30/14

## **Practice Guideline Compliance – Atypical Antipsychotics and Monitoring of Metabolic Side Effects**

### *Summary of project*

The intent of this Performance Improvement Project (PIP) is to improve processes such as timely metabolic lab documentation, review, and appropriate follow-up for clients prescribed atypical antipsychotics. BHI chose this topic as a PIP for several reasons. Primarily, the prevalence of metabolic side effects for atypical antipsychotics is getting national recognition as a problem that needs addressing. Secondly, BHI and its centers have been focusing on improving coordination and integration of care between physical and mental health through several initiatives over the past few years and addressing this current topic is a logical next step in continuing those efforts.

In FY10, BHI conducted a Focused Study exploring current provider practices in monitoring metabolic side effects. Through the process of conducting the Focused Study, BHI and its committees developed and adopted a practice guideline based on national standards for monitoring side effects for clients taking atypical antipsychotics. BHI believes that focusing on this topic across its service-region will improve awareness as well as encourage the drastic changes in both primary and mental health practices needed to improve conformance with our guideline.

This PIP is designed to improve processes such as timely metabolic lab documentation, review and appropriate follow-up for clients prescribed new atypical antipsychotics. BHI will develop resources and tools to assist our providers in implementing process changes. These process changes will help medication management teams refer clients in a timely manner for initial or ongoing labs based on BHI guidelines. As a result, clinicians will be able to catch and address changes in metabolic functioning earlier to minimize the effects on the client in order to prevent new onset or exacerbation of diabetes, dyslipidemia, and cardiovascular disease, and slowing or reversing weight gain. Discussing and addressing side effects collaboratively with the client will encourage better medication adherence and, ultimately, lead to better mental health outcomes. The ultimate goal of these interventions is improved client health.

Quantifiable Measure #1: Fasting plasma glucose lab documentation within 30 days prior to or up to 30 days after initiating a new atypical antipsychotic

Quantifiable Measure #1a: Follow-up within 30 days of lab documentation for clients with abnormal fasting plasma glucose results

Quantifiable Measure #2: Fasting lipid panel documentation within 30 days prior to or up to 30 days after initiating a new atypical antipsychotic

Quantifiable Measure #2a: Follow-up within 30 days of lab documentation for clients with abnormal fasting lipid panel results

*Goal from FY13*

- To coordinate with HSAG to ensure that projects are designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services while showing confidence in the reported improvements
- Meet all submission requirements and timelines for Monitoring Metabolic Labs & Follow-up for Clients on Atypical Antipsychotics

*Results and analysis*

FY12 served as the baseline measurement period for this PIP, and data was analyzed during FY13. FY13 data will be analyzed in fall 2013. Table 23 reflects the baseline results from FY12.

**Table 23: Baseline data for all quantifiable measures**

Quantifiable Measure	Numerator	Denominator	Rate
Measure 1 (Fasting plasma glucose lab documentation)	20	298	6.71%
Measure 1a (Follow-up for abnormal fasting plasma glucose results)	0	0	NA
Measure 2 (Fasting lipid panel documentation)	14	298	4.69%
Measure 2a (Follow-up for abnormal fasting lipid panel results)	4	7	57.14%

A full quantitative statistical analysis will be completed after the Re-measurement 1 period has ended. BHI has plans to compare the results from Baseline to Re-measurement 1 in November 2013. Some quantitative analysis was completed on baseline data results. The QI Research Analyst noted that a primary issue was lab tests were not even being ordered for a majority of clients. Specifically, of the 298 members in the sample, fasting plasma glucose lab tests were only ordered for 55 members (18.5%) and fasting lipid lab tests were only ordered for 48 members (16.1%). This is concerning as the actual measures (documentation of labs and follow-up for abnormal labs) cannot be assessed if lab tests are not even ordered.

Baseline measurement for Measure 1 is 6.71% and for Measure 2 is 4.69% and the goal for Re-measurement 1 is to increase that percentage by 5% each. Measure 2a measured at 57.14%, and the goal for Re-measurement 1 would be to increase by 10%. Measure 1a could not be calculated, as none of the labs documented were abnormal. Since only baseline measurement percentages were calculated there is no statistical test of p value to report. The results of the baseline measurement are lower than what BHI expected, based on the results from a previous focus study. However, BHI made more stringent reporting lab results requirements in this performance improvement project, which could have resulted in lower percentages.

*Barrier analysis and planned interventions*

The QI Team met with the QI Departments from each of the CMHCs to discuss barriers. To finalize the barrier analysis and determine interventions, the QI team met with the Chief Executive Officer and the Chief Medical Officer. The barriers identified that will take priority when implementing interventions for the period between baseline and Re-measurement 1 are: labs not being ordered, client education about importance of labs, and losing the lab/referral slip. Each intervention in the section below is related to these prioritized barriers.

One of the barriers identified in this study was that labs were not being ordered when a client started a new atypical antipsychotic medication. Some documented notes reflected that the need for the medication outweighed the possible metabolic side effects. Other documented notes reflected that previous labs were “normal.” However, a large percentage of providers were not ordering labs at the time the client started a new atypical antipsychotic medication. To help improve the ordering of labs by providers, BHI redistributed the practice guidelines to all clinical staff at the CMHCs through each respective QI Department. BHI also updated the website to include this practice guideline so providers could reference the document as needed.

Another intervention to help ensure providers order labs is the revision of the practice guideline. The Standards of Practice Committee will be meeting at the end of the fiscal year to discuss this guideline and possible revision. The Standards of Practice Committee involves BHI’s Chief Medical Officer and a Quality Improvement Research Analyst as well as Medical Directors and clinical staff from each of the three CMHCs. Once the practice guideline is revised, the website will be updated and the revised practice guideline will be distributed.

To address client education about the importance of getting labs done, the practice guideline was placed on the website under the Member tab. A Quality Improvement Research Analyst attended the BHI Member Advisory Board (MAB) meeting in March to address the practice guideline with clients. Once the practice guideline is revised, it will be presented in the MAB meeting again. A member mailer addressed the importance of completing labs and how to obtain a copy of the guideline via the website or by calling BHI.

Finally, a Quality Improvement Research Analyst will contact the Medical Directors of each CMHC to determine how referrals for labs are completed. This process will be evaluated and discussed among providers and possibly members to help coordinate labs being completed and lab results being available to providers. This intervention addresses the system/logistic issues with lab documentation.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Atypical Antipsychotics and Monitoring for Metabolic Side Effects	Meet all HCPF/HSAG requirements and deadlines for Performance Improvement Projects	Coordinate with HSAG to ensure that projects are designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services while showing confidence in the reported improvements	6/30/14
	Increase performance on Measures 1 and 2 by 5% in Re-Measurement period 1	Educate prescribers and members about the importance of lab testing and monitoring of metabolic side effects	
	Increase performance on Measures 1a and 2a by 10% in Re-Measurement period 1	Work with IT and medical support staff to improve communication and documentation of lab results and follow up	

## Evidence-Based and Promising Practices

### Summary of Project

Evidence-based practices typically refer to programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results. The implementation of proven, well-researched programs is standard practice and required by most funding sources. Promising practices are those that may have demonstrated efficacy through qualitative evaluation protocols but have not yet been supported by quantitative, peer-reviewed scientific publication.

### Goal from FY13

Develop or adopt practice guidelines and clinical practices based on valid and reliable clinical evidence or a consensus of health care professionals

### Results and analysis

Table 24 indicates the evidence-based and promising practices utilized by providers in the BHI network.

**Table 24: Evidence-based and promising practices**

For Adults	For Children
Adult Behavioral Health Promotions	Brief Hospitalization for suicidal children/adolescents
Assertive Community Treatment (ACT)	Child Parent Psychotherapy
Brief Dynamic Therapy	Child Behavioral Health Promotion Strategies
Cognitive Behavioral Therapy	Cognitive Behavioral Therapy
Crisis Services	Collaborative Problem Solving
Dialectical Behavioral Therapy	Crisis Services
Eye Movement Desensitization Reprocessing	Dialectical Behavioral Therapy
Illness Management and Recovery	Eye Movement Desensitization Reprocessing
Integrated Dual Diagnosis Treatment	Family-Based Cognitive Behavioral Therapy
Interpersonal Therapy	Functional Family Therapy
Member-run/Peer Services	Home-Based Services
Motivational Enhancement Therapy	Intensive Case Management
Motivational Interviewing	Love and Logic Parenting
Psychiatric Rehabilitation	Multimodal Treatment for ADHD
Psychoeducation for Families	Multi-Systemic Therapy
SAFE-T: SAMHSA mode for crisis assessments	Nurturing Parenting Program
Solution Focused Therapy	Parent Child Interaction Therapy
Supported Employment	Psychoeducation for Families
Supported Housing	School-Based Services
Trauma Recovery and Empowerment Therapy	Trauma-Focused Cognitive Behavioral Therapy

### Goal(s) for FY14

Project Title	Goal(s)	Action(s)	Target Date
Evidence-based and Promising Practices	Provide optimal care for members using well-researched clinical practice	Implement several additional measurements/metrics associated with the above evidence-based practices, to both measure outcomes of these practices and increase fidelity to the various models of treatment.	6/30/14

## Bipolar Education and Skills Training (BEST)

### *Summary of project*

BHI developed the Bipolar Education and Skills Training (BEST) program in 2004 with a multi-disciplinary and multi-modality group of clinicians seeking to collect the latest research, best practice models, and outcome data surrounding Bipolar Disorder. The BEST program serves both adults and adolescents with the following diagnoses: Bipolar Disorder I, Bipolar Disorder II, Bipolar Disorder NOS, or Cyclothymic Disorder.

BHI is currently working on the fourth edition of the BEST program. Every month, current BEST facilitators and members of the BHI QI team (also former facilitators of the BEST program) meet to discuss changes to be made to the program based on feedback from participants and the facilitators own clinical knowledge of treatment of Bipolar Disorders. The purpose of the revision of BEST is not only to incorporate new Bipolar knowledge into the curriculum, but also to make BEST a comprehensive program that can be completed by participants in a 12-16 week period.

### *Goals from FY13*

- Improve BEST data entry and reporting
- Recruit and train facilitators in BEST Third Edition
- Improve BEST Program and participant retention, graduate 20 BEST participants.
- Increase BEST participation, increase new participants to 50
- Publish 4<sup>th</sup> Edition of BEST

### *Results and analysis*

Mid-year, BHI shifted focus away from the recruitment of new facilitators in order to concentrate on the 4<sup>th</sup> edition revisions to the curriculum. The 4<sup>th</sup> edition has now undergone a complete restructuring in order to decrease the length of the program without compromising the content of the program, which should therefore increase member retention. New questionnaires and assessments have been created in order to drive BEST towards an evidence-based model with specific quantitative outcomes rather than qualitative outcomes.

### *Barrier analysis and planned interventions*

The length of the BEST curriculum has been the most challenging aspect of the text revisions. In order to effectively reduce the length of the curriculum, the QI department has had to balance reducing redundant content, combining related content, and improving outdated content. The QI department has been meeting more regularly to address the large workload for this project.

### *Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
BEST Program	Move the BEST program towards an evidence-based practice model	Publish and implement the fourth edition of the BEST program in FY14	6/30/14
		Gather more comprehensive data on treatment outcomes	
		Recruit and train new facilitators in the fourth edition, thereby increasing the number of members with access to the BEST program	

## **Member and Family Input in Quality Improvement Program**

Member and family involvement and input into the quality improvement program are vital to true service improvement. The QI program involves members and their families in a bi-directional manner, assuring that not only is member input driving improvement activities, but also that information about those quality improvement activities are being given back to members, increasing member education about the quality improvement process.

For example, a member of the BHI QI Department attends the Member Advisory Board meeting on a quarterly basis in order to educate members about the activities of the QI department (such as the revisions of the Atypical Antipsychotic Monitoring of Metabolic Side Effects and the importance of members obtaining lab screenings) and receive feedback about the barriers they may experience in obtaining those lab services.

Additional mechanisms for incorporating the member experience into the quality improvement department are outlined in the following sections:

- Member Satisfaction (MHCA Survey)
- Member Satisfaction (MHSIP, YSS, YSS-F Surveys)
- Grievances and Appeals
- Quality of Care Concerns

### **Member Satisfaction (MHCA Survey)**

#### *Summary of project*

Member evaluation of health plan services offered through Behavioral Healthcare Inc. (BHI) is critical to the identification of opportunities to improve all aspects of care provided to our members. BHI has conducted its member surveys since 1996. Satisfaction surveys provide BHI with knowledge on member perceptions of well-being, independence, and functional status as well as perceptions on the scope of services offered, accessibility to obtain services when needed, availability of appropriate practitioners and services, and acceptability or “fit” of the practitioner, ensuring program changes and services redesign in meeting the members’ unique needs and preferences. This feedback helps to modify the service system for actual utilization patterns and enables member choice. If a pattern is detected or there is a statistically significant level of concern, BHI requires and/or develops a corrective action plan.

As stated in its contract with HCPF, BHI conducts an annual internal satisfaction survey of both adult and youth members receiving services at its CMHCs, in BHI’s CPN, and in member-run Drop-in Centers using the Mental Health Corporation of America (MHCA) satisfaction survey. This data is then compared to a matched group of Medicaid members and other behavioral health agencies across the nation. This tool has been validated for use across a variety of service delivery modalities and can be utilized for analysis of youth and adult populations. BHI submits the results of this internal survey as well as its comparison data to HCPF annually.

For 2013, BHI conducted an additional survey of 15 questions to assess Utilization Management services and Access to Care as well as to assess more thoroughly, acceptability or “fit” of the practitioner, program design, and services in meeting the members’ unique needs and preferences. From February 13 through April 12, 2013, the surveys were administered at BHI’s CMHC sites and Drop-in Centers, and they were mailed to a random sample of CPN members.

The total population size used for determining the needed number of completed surveys was 15,444 members. This was the total number of members who received services from the start of FY13 (July 1, 2012) through January 24, 2013 when the sample was obtained. Using the sample size calculator, it was determined that 390 members was a sufficient overall sample size. The sample size calculator prepares a random sample where  $n = N/(1+(N*0.0025))$  where sample error & confidence level = 0.05 & 95% from study population, with a 5% oversample.

Based on previous year return rates, three times the amount of surveys needed to meet the sample size were mailed to a random selection of the CPN members. Included in the CPN mailing was a letter explaining the survey and the lottery process to win one of ten \$20 gift certificates to Target. A pre-paid stamped envelope was included for members to submit the completed surveys and lottery cards to BHI. Based on previous years return rates, BHI also provided the three MHC's and Drop-In Centers with three times the number of surveys needed to obtain the stratified sample for each site. 2,515 surveys were distributed and 862 completed surveys were returned, which indicates a 34.27% response rate.

Lottery tickets were provided for members to enter a drawing for one of ten \$20 gift certificates to Target. Both English and Spanish surveys and lottery tickets were made available. CMHC's and Drop-in Centers collected completed surveys and delivered to BHI. BHI mailed surveys to MHCA for data analysis and report generation.

*Goal from FY13*

Conduct Annual Internal Satisfaction Survey - Conduct Annual MHCA satisfaction survey on active members

*Results and Analysis*

Figure 13 shows the comparison between BHI results for the past four years, by category on the MHCA survey.

**Figure 13: BHI performance on the MHCA**

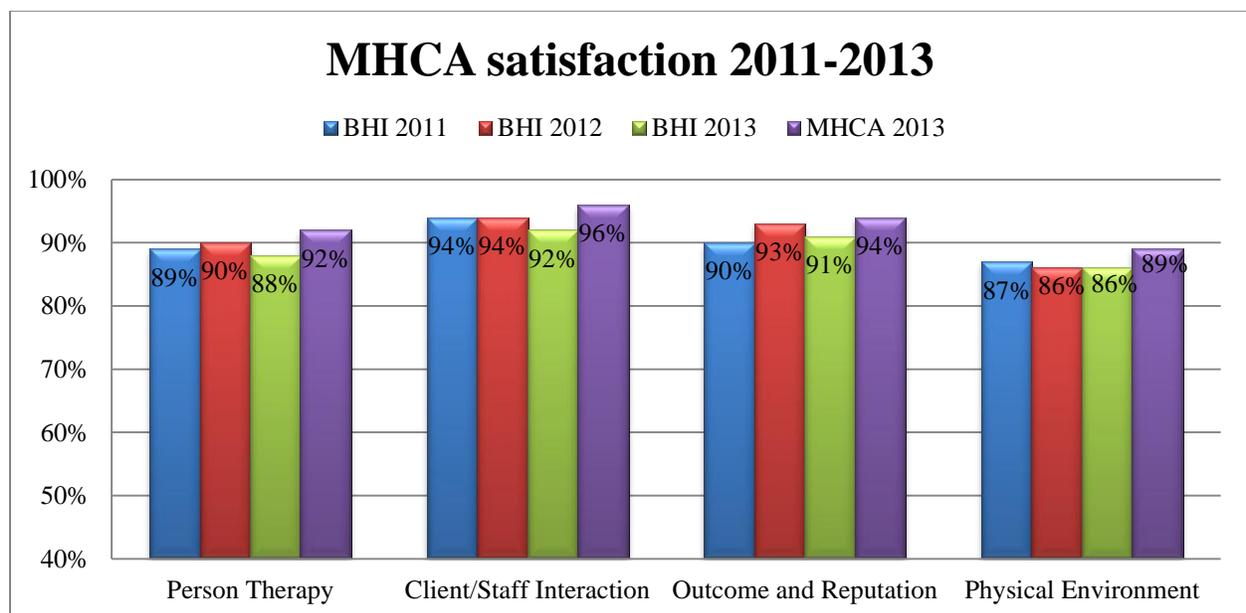


Table 25 shows the mean, standard deviation, and percentage of satisfaction for each of the four NCQA categories. For the mean and standard deviation the Poor, Fair, Good, Very Good, or Excellent possible responses were converted to a 1-5, with 1 being poor and 5 being excellent.

**Table 25: BHI performance on MHCA**

<b>FY13 Member Satisfaction Results</b>			
	<b>Mean</b>	<b>Standard Deviation</b>	<b>Percentage Satisfied*</b>
<b>Services</b>	3.53	1.67	91%
<b>Accessibility</b>	3.37	1.46	82%
<b>Availability</b>	4.00	1.06	91%
<b>Acceptability</b>	3.58	1.61	91%
<b>Overall</b>	3.43	1.57	86%

\*Percent of Good, Very Good, and Excellent responses in the survey questions for that category

BHI has not previously analyzed member satisfaction results by the four NCQA categories, but will continue to do so in the future. Because BHI has not previously categorized results in this manner, no benchmark for overall percentage of satisfaction, or by individual category has been determined.

*Barrier analysis and planned interventions*

BHI recognizes that while the overall sample size was adequate, the number of returned surveys from the CPN were low. BHI plans to address this issue in future member satisfaction surveys by allowing several CPN sites to handout the survey when members are present for appointments. BHI is going to discuss the results in both the Performance Evaluation and Outcomes (PEO) committee meeting as well as in the Provider Advisory Council (PAC) to address ways to increase the number of returned surveys for next year's survey.

Since the accessibility category showed the lowest level of satisfaction, BHI will concentrate interventions in that area. Currently, BHI assesses this through the annual access to care report, and has planned interventions that should help improve the satisfaction score next year. Planned interventions for access to care include: provider and member education on access to care standards, quarterly secret shopper calls, and monitoring overall access to care annually.

BHI believes that member satisfaction does not need any specific interventions at this time. The overall results are comparable to previous year's results. BHI will consider improving the response rate; however, a 25% response rate is expected based on previous year's surveys. BHI will also continue to monitor access to care to improve the accessibility category.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Conduct MHCA satisfaction survey on active members	6/30/14
		Increase return rate of MCHA surveys by 10%	
		Meet or exceed satisfaction results from FY13	

## **Member Satisfaction (MHSIP, YSS, YSS-F Surveys)**

### *Summary of project*

The Colorado Office of Behavioral Health (OBH) conducted its annual Mental Health Statistics Improvement Program (MHSIP) Consumer Survey with a focus on services provided in State Fiscal Year 2012 (July 1, 2011-June 30, 2012). OBH administers the MHSIP Consumer Survey to assess perceptions of behavioral health services provided in Colorado.

The MHSIP Consumer Survey consists of 36 items, each answered using a Likert scale ranging from one (strongly agree) to five (strongly disagree). Standardized at a national level, the survey comprises of the following domains:

- Access (six items that assess perceptions about service accessibility)
- Quality/Appropriateness (nine items that assess perceptions of quality and appropriateness)
- Outcomes (eight items that assess perceptions of outcomes as a result of service)
- Participation (two items that assess perceptions of member involvement in treatment)
- General Satisfaction (three items that assess satisfaction with services received)

Additionally, one item assesses perceived provider sensitivity to cultural/ethnic backgrounds of members. The questionnaire also contains items pertaining to demographic information (e.g. age, ethnicity). In addition, two open-ended questions are included in order to gather opinions about the most and least preferred aspects of services received. OBH distributes that MHSIP Consumer Survey in both English and Spanish.

The Youth Services Survey for Families (YSS-F) was modeled after the MHSIP. A modification of the MHSIP survey for adults, the YSS-F assesses caregivers' perceptions of behavioral health services for their children (aged 14 and under). Caregivers complete items pertaining to demographic (e.g. age, gender) and other pertinent information (e.g. medication, police encounters) about their child. Caregivers then use a Likert scale, ranging from strongly agree to strongly disagree to answer 21 items that include the following five domains:

- Access (two items)
- Appropriateness (six items)
- Outcomes (six items)
- Participation (three items)
- Cultural sensitivity (four items)

This year, the Youth Services Survey was also offered, allowing young adult consumers to complete their own survey on their perceptions of behavioral health services.

### *Goal from FY13*

Support OBH in the MHSIP survey process and incorporate survey data into any interventions designed to improve member satisfaction.

*Results and analysis*

Table 26 below displays BHI’s results from FY12 as compared to the statewide BHO average performance.

**Table 26: BHI performance on the MHSIP, YSS, and YSS-F**

<b>MHSIP</b>	<b>Total</b>	<b>Not Satisfied</b>	<b>Satisfied</b>	<b>Percent Satisfied</b>	<b>BHO Average</b>
Perception of Access	332	51	281	84.64%	84.35%
Perception of Appropriateness and Quality	331	38	293	88.52%	89.55%
Perception of Outcomes	321	101	220	68.54%	62.91%
Perception of Participation in Treatment	314	69	245	78.03%	80.39%
Perception of Satisfaction	208	26	182	87.50%	89.98%

<b>YSS</b>	<b>Total</b>	<b>Not Satisfied</b>	<b>Satisfied</b>	<b>Percent Satisfied</b>	<b>BHO Average</b>
Perception of Access	65	15	50	76.92%	75.53%
Perception of Appropriateness and Quality	66	10	56	84.85%	84.15%
Perception of Outcomes	66	23	43	65.15%	65.37%
Perception of Participation in Treatment	61	8	53	86.89%	86.74%
Perception of Cultural Sensitivity	65	4	61	93.85%	93.86%

<b>YSS-F</b>	<b>Total</b>	<b>Not Satisfied</b>	<b>Satisfied</b>	<b>Percent Satisfied</b>	<b>BHO Average</b>
Perception of Access	178	33	145	81.46%	76.32%
Perception of Appropriateness and Quality	180	32	148	82.22%	81.84%
Perception of Outcomes	179	69	110	61.45%	57.50%
Perception of Participation in Treatment	176	19	157	89.20%	90.89%
Perception of Cultural Sensitivity	164	11	153	93.29%	92.54%

*Barrier analysis and planned interventions*

BHI received feedback from each of the CMHCs that the survey collection period for these surveys is very short (only 2 weeks) and therefore they are able to reach only a limited number of members. In addition, each of the surveys is rather long, resulting in survey burnout for many members. BHI provided this feedback to OBH. During the summer of 2013, OBH created a workgroup to look at revising and shortening the surveys in order to increase response rate. Each of the CMHCs in the BHI catchment area sent a representative to this workgroup. BHI plans to work with the CMHCs to coordinate member satisfaction surveys as to avoid survey burnout.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Support OBH in the MHSIP survey process and incorporate survey data into any interventions designed to improve member satisfaction.	6/30/14

## Grievances and Appeals

### *Summary of project*

It is the policy of Behavioral Healthcare Inc. (BHI) to support the rights of clients, family members and interested others to register concerns and/or file grievances related to any issue regarding the care received through BHI and provide reasonable assistance in completing any forms requested. The purpose of this policy is to ensure that clients and interested others have a means of providing ongoing feedback to the BHI system which results in prompt resolution of individual problems, the tracking or problematic trends within the system, an overall improvement in the quality of services, and the prevention of retaliation.

### *Goal from FY13*

No goal was identified in the FY13 Quality Improvement Work Plan. However, during the year BHI formalized the goal of collecting and analyzing grievance and appeal data and implement targeted interventions if patterns or trends emerge.

### *Results and analysis*

In an effort to monitor member and family concerns about quality of care issue, BHI operates a comprehensive grievance tracking and resolution process. Figure 14 shows the trend in number of grievances for the past four quarters.

**Figure 14: Grievance data by quarter**

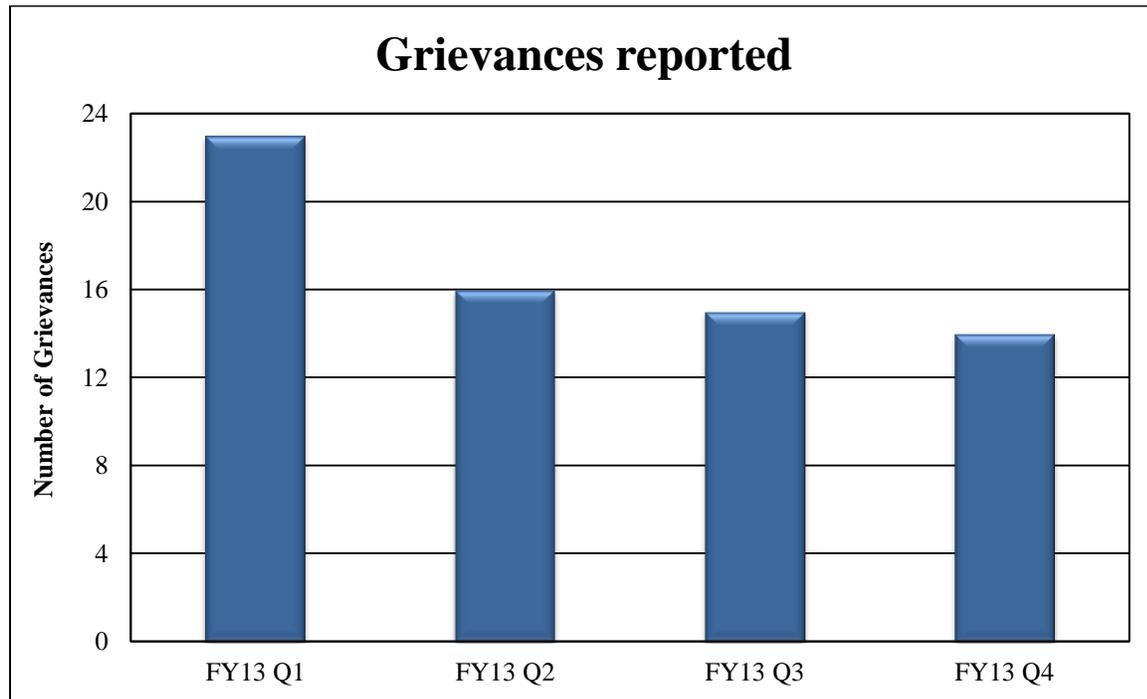


Table 27 shows the number of complaints and appeals by NCQA category for the past year, by quarter. Note: BHI defines a “grievance” as a member complaint.

**Table 27: Grievances by category, by quarter**

2012 - 2013 Grievances by Category						
Category	FY13 Q1	FY13 Q2	FY13 Q3	FY13 Q4	Total by Category	Percentage of Total
Quality of Care	12	6	4	9	31	43%
Access	6	2	2	2	17	24%
Attitude and Service	2	3	9	2	17	24%
Billing and Financial Issues	0	1	0	0	2	3%
Quality of Practitioner Office Site	2	1	0	1	5	7%

BHI was concerned about the number of grievances received related to attitude and service (reported as customer service by BHI). The attitude and service category includes but is not limited to:

- Discourteous treatment by provider administrative staff
- Discourteous/rude treatment by clinical staff
- Appointment scheduling errors
- Inaccurate information provided

Upon review of a request for mental health services, if BHI determines that the request for service does not meet medical necessity a notice of action is given. If the member is dissatisfied with the Notice of Action, they have a right to appeal this action locally and/or through a State Fair Hearing. Table 28 shows the type of action taken in FY13 as well as the type of action per CMHC and for BHI.

**Table 28: Notices of action**

Type of Action Taken	FY13 Q1	FY13 Q2	FY13 Q3	FY13 Q4
Denial or limited authorization of a requested service, including the type or level of service	14	15	25	16
Reduction, suspension or termination of a previously authorized service		1		
<b>Community Mental Health Center</b>				
Arapahoe Douglas Mental Health Network	4	8	6	7
Aurora Mental Health Center	2	1	4	1
Community Reach Center	7	3	9	5
Behavioral Healthcare, Inc.	1	4	6	3

Both grievances and appeals are analyzed by quarter and addressed by the Office of Member and Family Affairs and the Utilization Management Department. BHI does not set “goals” for the number of appeals or grievances filed as members are encouraged to file for both as often as needed and necessary.

BHI understands that the majority of the grievances are going to be in the quality of care, access, and attitude and service categories. BHI has seen a decrease in the number of access related grievances in the past three quarters. There has also been a steady decrease in the number of quality of care grievances. BHI attributes this decline to improving its quality of care concerns process and procedure in the past year.

*Barrier analysis and interventions*

In Q3 there was an increase in the number of grievances related to discourteous/rude treatment by clinical staff. The BHI Quality Improvement staff reviewed each grievance and was unable to determine a pattern, but decided to ask the CMHCs to send a memorandum reminding all staff to be respectful and courteous to members at all times. In FY13 Q4, BHI handled two grievances related to this same topic, which is a decrease from the six in the previous quarter.

*Goal(s) for FY14*

<b>Project Title</b>	<b>Goal(s)</b>	<b>Action(s)</b>	<b>Target Date</b>
Grievances and Appeals	Ensure that clients and interested others have a means of providing ongoing feedback to the BHI system	Continue to collect and analyze grievance and appeal data through the quarterly Performance Report Card and implement interventions if patterns or trends emerge.	6/30/14

## Quality of Care Concerns

### *Summary of project*

BHI's Quality of Care Concerns (QOCC) system identifies, investigates, and addresses potential quality of care concerns, including those involving physician providers. QOCC detection is permanently built into BHI's standard operating procedures and requirements. QOCCs include all potential problems, concerns, or complaints concerning access to urgent or emergent care, delay or denial of care or services, after-hours services, professional conduct or competence, coordination of care, medication issues, diagnosis issues, service plan or delivery issues, or concerns with legal or member rights. QOCCs are also triggered by care resulting in unexpected death, suicide attempts requiring medical attention, medication errors or adverse medication effects requiring medical attention, preventable complication requiring medical attention, assault or accident related injuries requiring medical attention, or an at-risk client missing from a 24-hour facility.

A potential quality of care concern regarding one or more BHI members can be reported to BHI by any of the following entities: the Colorado Department of Health Care Policy and Financing (HCPF), an employee of BHI, a Client Representative, a clinician, or an external agency. Any concerns raised by a member will be forwarded to the Office of Member and Family Affairs to be handled as a grievance.

### *Goal from FY13*

No goal for QOCCs was outlined in last year's Quality Improvement Plan.

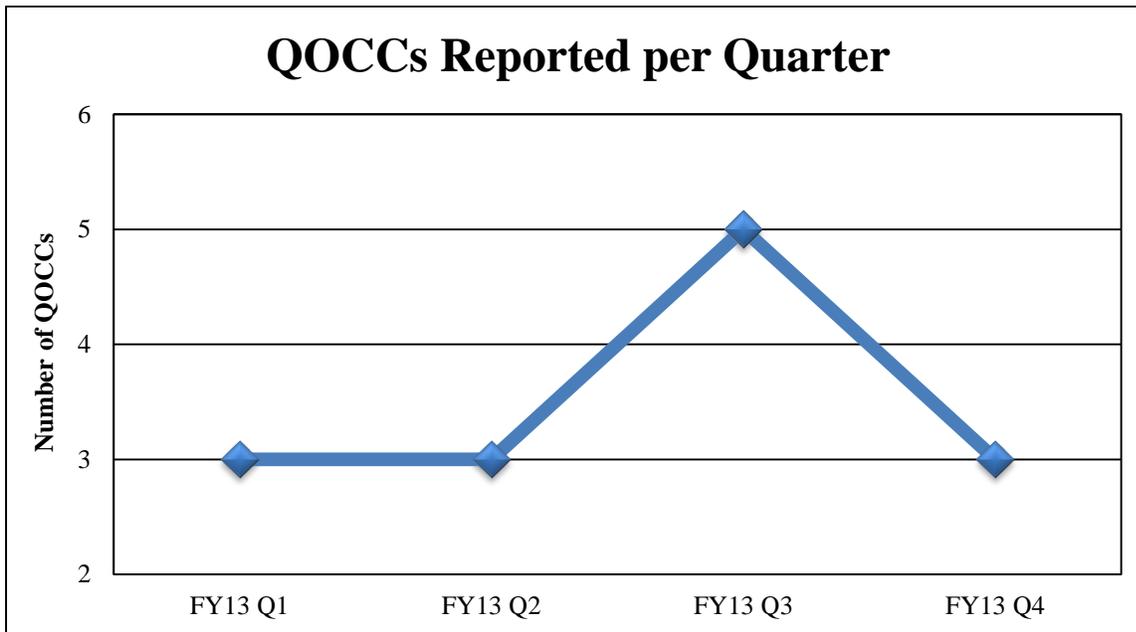
### *Results and analysis*

To date in FY13, BHI has investigated 14 QOCCs. Two reports were unsubstantiated with an appropriate level of care. Twelve reports were substantiated and had the potential for an adverse outcome. For these issues, corrective action plans were completed and implemented by the CMHC or facility involved and resulted in changes to the applicable programs to assure a better quality of care. Table 29 below indicates the categories of the QOCCs reported in FY13, whereas Figure 15 indicates the number of QOCCs reported in each quarter of FY13.

**Table 29: Categories of FY13 QOCCs**

QOCC Category	Unsubstantiated	Substantiated	In Progress
Urgent/Emergent Care	1	0	0
Medication Issues	0	4	0
Coordination of Care	1	6	0
Delay of Care/Services	0	2	0

**Figure 15: QOCCs reported by quarter in FY13**



*Barrier analysis and interventions*

Throughout the year, it became evident that BHI’s internal QOCC process needed improvement, including policy and form revisions, provider education about the types of QOCCs, and formalizing the corrective action plan process. Many providers found the QOCC notification form to be confusing and therefore were reporting circumstances that certainly required problem solving or improvement in provider coordination, yet did not rise to the level of a QOCC investigation.

Therefore, the QI department clarified several aspects of the QOCC process, including:

- Revising the QOCC policy for clarity
- Simplified the QOCC notification form
- The development of a final report that summarizes the entire QOCC investigation, including any corrective actions taken by the provider
- Formalized the Corrective Action Plan (CAP) process through the use of a standard CAP form and formal approval of all corrective actions.
- Educating providers and the CMHCs about the QOCC process through the PEO Committee, the UM Committee, and the Provider Bulletin

*Goal(s) for FY14*

Project Title	Goal(s)	Action(s)	Target Date
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/14
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	
		Educate providers about the QOCC process	

## Quality Improvement Plan for FY14

Project Title	Goal(s)	Action(s)	Target Date
<b>Member Population</b>			
Penetration Rates	Increase overall penetration rate by 2% from 11.28%.	Continue to assess penetration rates by age, race, and eligibility type to better target interventions	6/30/14
		Use Geo-Coding project to better target interventions	
<b>Network Adequacy</b>			
Network Adequacy – Ensuring Availability	Meet the geographical needs of members by assuring provider availability	Continue to assess provider network availability against BHI standards and respond to the needs of the ever-growing Medicaid population.	6/30/14
Network Adequacy – Cultural Needs and Preferences	Meet the cultural, ethnic, and linguistic needs of members by assuring diverse provider network	Develop a mechanism to identify cultural and linguistic makeup of provider network to assess whether they meet members’ language needs and cultural preferences.	1/1/14
		Take action if network does not meet members’ language needs and cultural preferences.	
<b>Access to Services</b>			
Access to routine, urgent, and emergency services	Provide access to covered services as indicated in the Medicaid standards for access to care	Increase provider education about access to care standards	1/1/14
		Increase frequency of secret shopper calls to CPN providers	
		Educate members about definitions of routine, urgent, and emergent appointments and the associated standards	
Access to medication evaluations	Provide access to medication evaluations within 30 days of client request for service	Assist providers in barrier analyses to identify opportunities to improve access to medication evaluations.	6/30/14
Focal point of behavioral health services	Continue to perform at or above the statewide average for this performance indicator.	Continue to monitor clients’ accessibility to services	6/30/14
<b>Compliance Monitoring</b>			
External Quality Review Organization (EQRO) audit	Continue to score at or above the previous year’s performance	Participate in annual, external independent reviews of the quality of services covered under the Medicaid contract	6/30/14
		Coordinate with HSAG (Health Services Advisory Group) to comply with review activities conducted in accordance with federal EQR regulations 42 C.F.R. Part 438 and the CMS mandatory activity protocols	
Performance Improvement Projects and Focused Studies	Develop research projects designed to improve the quality of client care	Participate in the HCPF statewide Performance Improvement Project (PIP) and meet all requirements.	6/30/14
Substance Use Disorder (SUD) Services	Provide SUD services in a manner consistent with other behavioral health services	Develop methods for incorporating SUD services into current performance indicators (Access to Care, Network Adequacy, Member Satisfaction, Provider Audits, etc.)	4/1/14
Encounter Data Validation (411) Audit	Improve provider claims review to a compliance score of 80% or higher	Continuing to train providers on proper billing and documentation practices	6/30/14
	Maintain or improve inter-rater reliability with HSAG	Continuing to train audit team on the USCS Manual	

Project Title	Goal(s)	Action(s)	Target Date
<b>Compliance Monitoring (continued)</b>			
Delegation Oversight	Re-design Utilization Management department in order to manage all service authorizations 24 hours per day, 7 days per week	Transition the remaining delegated authorizations from the CMHCs back to BHI without interrupting client care	10/1/13
		Train all relevant service providers on authorization changes	
	Oversee the quality of activities delegated to any subcontractor	Continue to monitor the activities delegated to Colorado Access as our Administrative Service Organization through Delegation Oversight Audits	6/30/14
Provider claim/record audits	Improve provider documentation and reduce incidence of waste and abuse in billing practices	Continue to develop the audit process and educate providers about compliance requirements	6/30/14
		Initiate a minimum of 10 provider audits	
<b>Performance Measures</b>			
Reducing Cost of Care	Continue to perform at or above the statewide BHO average for performance measures.	Continue to measure performance indicators quarterly to monitor for patterns and trends across services	6/30/14
		Continue to monitor specific member utilization for targeted member interventions	
		Continue to develop peer specialist program to assist in targeted member interventions	
Member Health and Safety	Perform at or above the statewide BHO average for performance measures.	Assess need for quarterly calculation of performance measures to better target interventions.	1/1/14
Coordination of Care – Follow-up after hospital discharge	Provide 90% of outpatient appointments within 7 days after hospital discharge	BHI will continue to monitor this measure quarterly and implement targeted interventions	6/30/14
	Provide 95% of outpatient appointments within 30 days of hospital discharge		
Coordination of Care – Improving physical healthcare access	Continue to improve coordination of care	Continue to develop the Care Management Program	6/30/14
	Improve measurement of coordination of care	Develop Quarterly Performance Measure to identify the percentage of members receiving services who are linked with a PCP	1/1/14
Improving Member Functioning	Continue to measure and monitor performance	Cooperate with HCPF on the calculation of performance measures	6/30/14
Information Systems Capabilities Assessment Tool (ISCAT) audit	Continue to achieve 100% compliance on the audit	Continue to monitor and assess each aspect of the performance measure calculation process and adjusting accordingly	6/30/14
<b>Clinical Practice Guidelines and Evidence-Based Practices</b>			
Clinical Practice Guidelines	Develop and implement practice guidelines to meet the clinical needs of members and improve consistency across providers	Develop or adopt practice guidelines based on valid and reliable clinical evidence or a consensus of health care professionals	6/30/14
		Review all current practice guidelines every 2 years (or as necessary)	
Compliance with Clinical Practice Guidelines	Monitor providers' compliance with BHI clinical practice guidelines	Revise the EMDR practice guideline to reflect current evidence-based practices and distribute to all EMDR providers	9/1/13
		Continue to monitor compliance with at least two aspects of at least two clinical practice guidelines	6/30/14

Project Title	Goal(s)	Action(s)	Target Date
<b>Clinical Practice Guidelines and Evidence-Based Practices (continued)</b>			
Atypical Antipsychotics and Monitoring for Metabolic Side Effects	Meet all HCPF/HSAG requirements and deadlines for Performance Improvement Projects	Coordinate with HSAG to ensure that projects are designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and services while showing confidence in the reported improvements	6/30/14
	Increase performance on Measures 1 and 2 by 5% in Re-Measurement period 1	Educate prescribers and members about the importance of lab testing and monitoring of metabolic side effects	
	Increase performance on Measures 1a and 2a by 10% in Re-Measurement period 1	Work with IT and medical support staff to improve communication and documentation of lab results and follow up	
Evidence-based and Promising Practices	Provide optimal care for members using well-researched clinical practice	Implement several additional measurements/metrics associated with the above evidence-based practices, to both measure outcomes of these practices and increase fidelity to the various models of treatment.	6/30/14
BEST Program	Move the BEST program towards an evidence-based practice model	Publish and implement the fourth edition of the BEST program in FY14	6/30/14
		Gather more comprehensive data on treatment outcomes	
		Recruit and train new facilitators in the fourth edition, thereby increasing the number of members with access to the BEST program	
<b>Member and Family Input into the QI Program</b>			
Member Satisfaction Surveys	Continue to monitor and improve member satisfaction with services	Conduct MHCA satisfaction survey on active members	6/30/14
		Increase return rate of MCHA surveys by 10%	
		Support OBH in the MHSIP survey process and incorporate survey data into any interventions designed to improve member satisfaction.	
		Meet or exceed satisfaction results from FY13	
Grievances and Appeals	Ensure that clients and interested others have a means of providing ongoing feedback to the BHI system	Continue to collect and analyze grievance and appeal data through the quarterly Performance Report Card and implement interventions if patterns or trends emerge.	6/30/14
Quality of Care Concerns	Address any potential member safety issue	Continue to trend QOCCs by provider and by category and address any patterns	6/30/14
		Continue to work with individual providers on corrective actions if a QOCC is substantiated	
		Educate providers about the QOCC process	